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IN THE COURT OF COMMON PLEAS
 CUYAHOGA COUNTY, OHIO
 MARY LOU ZIMMERMAN,
 et al.,
 Plaintiffs,
 -vs- JUDGE BURNSIDE
 CASE NO. 399411
 THE CLEVELAND CLINIC FOUNDATION,
 Defendant.

- - -

Deposition of STEVEN M. GORDON, M.D., taken as if
 upon cross-examination before Laura L. Ware, a
 Notary Public within and for the State of Ohio, at
 The Cleveland Clinic Foundation, 9500 Euclid Avenue,
 S-32 Conference Room, Cleveland, Ohio, at 5:10 p.m.
 on Friday, October 27, 2000, pursuant to notice
 and/or stipulations of counsel, on behalf of the
 Plaintiffs in this cause.

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On behalf of the Defendant.

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(Thereupon, Plaintiffs' Gordon Exhibit
 1 was mark'd for purposes of identification.)

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STEVEN M. GORDON, M.D., of lawful age,
 called by the Plaintiffs for the purpose of
 cross-examination, as provided by the Rules of Civil
 Procedure, being by me first duly sworn, as
 hereinafter certified, depose and said as follows:
 CROSS-EXAMINATION OF STEVEN M. GORDON, M.D.

BY MR. LINTON:

Q. Dr. Gordon, good evening. We met a moment ago. My
 name is Bob Linton. Mark Ruf and I represent Mary
 Lou Zimmerman and her husband, Sherman Zimmerman, in
 a case that's pending against The Cleveland Clinic.

I assume you've had your deposition taken
 before?

A. I have.

Q. Please stop me if you don't understand one of my
 questions and I'll do everything I need to do to
 make sure you understand the question.

A. I appreciate that.

Q. If you answer the question without asking for
 clarification, we'll assume you've understood the
 question. Fair enough?

4

A. Fair enough.

Q. You provided to us at the start of your deposition a
 CV dated May of 2000. Was that current as of that
 date?

A. Yes, it was.

Q. Are there any additions to make since May of 2000
 that would impact on this particular case, Mary Lou
 Zimmerman's case?

A. Not that I would be aware of.

Q. What is your current position at The Cleveland
 Clinic?

A. Staff physician, Department of Infectious Disease
 with a dual appointment at the transplant center and
 hospital epidemiologist.

Q. So you are a physician specializing in both
 infectious disease as well as epidemiology?

A. That's correct.

Q. Do you have certifications in both?

A. Certification in infectious disease. There really
 is no certification in hospital epidemiology, that I
 am aware of.

Q. What additional training or, well, training do you
 have in epidemiology?

A. Three years at the Center for Disease Control, EIS,
 Epidemic Intelligence Service under the mentorship

5

1 of Bill Jarvis, Jim Hughes, Bill Martone.
 2 Q. Are you currently the Chairman of the Infection
 3 Control Committee here at the Clinic?
 4 A. Yes.
 5 Q. How long have you had that position?
 6 A. I've probably been chairman since '95, January of
 7 '95, approximately.
 8 Q. How long have you been employed at The Cleveland
 9 Clinic?
 10 A. August of '93.
 11 Q. Did you hold any positions relative to the Infection
 12 Control Committee before taking over as chairman?
 13 A. Associate Chairman.
 14 Q. For how long?
 15 A. From '83 until approximately 1 of '95. I'm sorry,
 16 '93 until 1 of '95.
 17 Q. And how much of your professional time is spent as
 18 Chairman of the Infection Control Committee here at
 19 the Clinic?
 20 A. It would be hard to quantify. 30 percent of my
 21 hundred percent FTE is officially at that, but --
 22 Q. Help me out. What is FTE?
 23 A. Well, one FTE equals 1.0, so .3 is supported at the
 24 hospital for epidemiology.
 25 MR. MALONE: You don't know that?

6

1 That's the biggest term to know. That's a
 2 full-time employee.
 3 MR. LINTON: It would have been my next
 4 guess. All right, okay.
 5 MR. MALONE I didn't mean to
 6 interrupt.
 7 MR. LINTON: Kind of what Marilena is.
 8 MS. DISILVIO: I'm a half.
 9 MR. LINTON: Around-the-clock employee,
 10 okay.
 11 Q. So 30 percent of your time at The Cleveland Clinic,
 12 approximately, is devoted to your work as the
 13 Chairman of the Infection Control Committee?
 14 A. Like I said, it's hard to say. 30 percent of my
 15 salary is supported for that, let's just say.
 16 Q. Fair enough. What do you do in that position?
 17 A. That position, philosophically on paper there's five
 18 Infection Control Practitioners currently at the
 19 Clinic whom we meet at least twice a week, more if
 20 necessary, as well as an Associate Chairman, Dr.
 21 Steven Schmidt.
 22 Hospital epidemiology has moved also to health
 23 care epidemiology, so we discuss issues
 24 traditionally about, say, infection rates, quote,
 25 unquote, but expand it to employee health issues,

7

1 issues about health care systems. We're moving
 2 toward also reduction of errors in systems of that
 3 nature to post-exposure needle sticks, TB control,
 4 so it's a variety. I would like to view ourselves
 5 as hopefully someone, a group, that people turn to
 6 for help in solving problems.
 7 Q. Related to infection --
 8 A. Not necessarily.
 9 Q. --control?
 10 A. It's not always related to infection.
 11 Q. The five practitioners on the committee, do they
 12 have certain responsibilities?
 13 A. Yes. In terms of how it's divided up, we, you know,
 14 they all can cross cover one another but each has
 15 their focal areas, or, say, primary responsibility.
 16 Q. Who are those five practitioners?
 17 A. Well, actually we just lost one, but Mary Bertin
 18 would be the one, Dirk would be another, Dirk
 19 Treleven.
 20 Q. Can you spell the last name?
 21 A. T-R-E-L-E-V-E-N. Linda Madison and Cindy Fatica.
 22 Jan Serkey just departed two weeks ago.
 23 Q. Mary Bertin, is she still on the committee?
 24 A. Yes, she is. Yes, she's an ICP. They're all on the
 25 committee, but they're all Infection Control

8

1 Practitioners.
 2 Q. What is an ICP?
 3 A. An Infection Control Practitioner is someone who's
 4 certified, they don't have to be a nurse, although
 5 all of them are nurses, and their goal, again, their
 6 philosophy, is to help in terms of some of the
 7 missions that we have.
 8 Q. Mary Bertin's responsibility would include
 9 surveillance of neurosurgical surgeons?
 10 A. Yeah, Mary has spearheaded that probably since 1998
 11 in terms of being the primary Infection Control
 12 Practitioner for part of our targeted surveillance,
 13 which would include all clean neurosurgical site
 14 infections.
 15 Q. And how would you define a neurosurgical site
 16 infection?
 17 A. By CDC definitions, any clean surgical site
 18 infection that occurs within 30 days of operation,
 19 defined classically by pus at the wound, but
 20 other --there are other definitions that, you know,
 21 we could look up, but that's basically I think a
 22 standard definition.
 23 Q. Is that different than an organ space infection?
 24 A. Organ space infection can be a type of surgical site
 25 infection.

9

- 1 Q. Do you make a distinction in your analysis here at
2 the Clinic?
- 3 A. Occasionally. I mean, it depends on what we're
4 doing surveillance for, the types.
- 5 Q. How would you define an organ space infection?
- 6 A. Organ space infection, again, is going to be
7 something that's deeper than the subcutaneous
8 tissue, usually below the fascia. So depending on
9 what organ has been operated on, that generally, you
10 know, would be defined as an organ space infection.
- 11 Q. What materials did you review -- well, how does an
12 organ space infection differ from a surgical wound
13 infection?
- 14 A. Well, an organ space infection can be a subset of a
15 surgical wound infection. Generally speaking, organ
16 space infections, if it's after a surgical site
17 infection, would be considered a deep infection and
18 often more serious.
- 19 Q. A surgical wound infection can include an organ
20 space infection?
- 21 A. Sure.
- 22 Q. Does it matter which causes which?
- 23 A. That I don't understand.
- 24 Q. Can a surgical wound infection include an organ
25 space infection that, in fact, causes then the

10

- 1 surface wound infection? Do you understand what I'm
2 saying, a chicken or an egg analysis in terms --
- 3 A. Well, I guess you only get one. If it's surgical
4 site infection?
- 5 Q. Yes.
- 6 A. That's -- then you can categorize it as deep or
7 superficial, which may or may not include a
8 subdivision of organ space infection, but you can't
9 have it both ways.
- 10 Q. Can you have a surface wound infection that is also
11 deep that would also include the brain?
- 12 A. Yes, that's possible.
- 13 Q. Now, what materials did you review to prepare for
14 your deposition today?
- 15 A. You mean in my whole training or specifically
16 targeted for here?
- 17 Q. Specifically for this deposition today.
- 18 A. Oh, I read over the medical records of Ms. Zimmerman
19 and the depositions of Dr. Barnett, Dr. Avery and
20 Dr. Rehm.
- 21 Q. Were you involved in any way with the treatment of
22 Mary Lou Zimmerman while she was in the hospital?
- 23 A. I don't believe so. I did not see my name on any of
24 the notes.
- 25 Q. What do you understand, based on the information you

11

- 1 reviewed, happened to Mary Lou Zimmerman?
- 2 A. I don't understand that question.
- 3 Q. Okay. You understand Mary Lou Zimmerman was a
4 patient here?
- 5 A. Correct.
- 6 Q. And she had surgery?
- 7 A. Correct.
- 8 Q. What type of surgery did she have?
- 9 A. She had an ablation surgery. It was cingulotomies,
10 which are, you know, the point at which -- obviously
11 you could talk to Dr. Barnett, but essentially where
12 a probe is placed and a certain amount of
13 electricity is involved to interrupt the fibers, and
14 I think in her case done in four different areas
15 over her frontal lobe, both right and left side.
- 16 Q. But what complications developed from that
17 procedure?
- 18 A. The complications, again, only reading it through
19 the chart, it looks like she had some issues in
20 terms of mental status changes postoperatively and
21 eventually was found to have a polymicrobial blood
22 stream infection and wound infection post-op 12 to
23 14 days.
- 24 Q. Was she felt to have a brain abscess?
- 25 A. I believe she was clinically found to have a brain

12

- 1 abscess, although histopathologically that was not
2 proven.
- 3 Q. With reasonable probability do you believe that she
4 had a brain abscess, based on what you reviewed?
- 5 A. I believe there was an abscess. How deep it went, I
6 can't, you know, I can't be certain by my review of
7 those records.
- 8 Q. But you would agree it went into the brain, it was
9 inside the brain, the abscess?
- 10 A. I can't say for certain, no.
- 11 Q. Are you able to say with reasonable medical
12 probability that the abscess went outside the
13 brain?
- 14 A. Oh, she definitely had purulent drainage from both
15 probe holes.
- 16 Q. Did you see on the discharge summary that she was
17 noted to have a brain abscess?
- 18 A. I don't remember, although I believe that if you say
19 it's in there that it's in there.
- 20 Q. Why don't you take a look at the discharge summary
21 just so you have that. Down there at the bottom.
- 22 A. Maybe you can point out where it is. Brain
23 abscess. It's in the discharge -- it's the other
24 diagnosis.
- 25 Q. Would you disagree with that diagnosis?

13

1 MS. DISILVIO: Objection. That's not
2 what he said, but go ahead.
3 A. Yeah, like I -- from my point of view, I can't tell
4 you from my review of the chart that she definitely
5 had a brain abscess.
6 Q. Can you definitely rule out that she did not have a
7 brain abscess?
8 A. No, no, no.
9 Q. Okay. So you're not in a position to contradict
10 that?
11 A. No.
12 Q. Do you have any other explanation for the changes on
13 the CAT scan besides brain abscess?
14 A. I have not officially reviewed the CAT scan. I've
15 seen the CAT scan reports, but suffice it to say
16 that any postoperative patient the differential of
17 fluid would include pus, water and blood, so nothing
18 pathopneumonic there.
19 Q. You did read Dr. Barnett's deposition?
20 A. I can't say I read every word, but, yes, I reviewed
21 it.
22 Q. Do you recall when he testified that the area of the
23 abscess was in the same area of the brain in which
24 he would have inserted the probe for the right
25 cingulotomy?

14

1 A. If you say that, I would not dispute it.
2 Q. Let's assume that's what he testified to. Do you
3 have any reason to dispute that?
4 A. That the area of the pus came from the surgical site
5 infection, I mean wound, that was made at surgery?
6 Absolutely not.
7 Q. And that it actually was inside the cingulate gyrus
8 where he would have inserted his probe for the right
9 cingulotomy?
10 A. If that's what he said, I wouldn't --
11 MR. MALONE: I'm going to object. I
12 don't think that's the testimony. If you've
13 got the line and the passage why don't you show
14 it to him.
15 MR. LINTON: I'm asking him to assume
16 that to be true.
17 A. If that's what Dr. Barnett said, I have no reason to
18 disagree with that.
19 Q. Did you also see his testimony where he said that
20 the abscess at Mary Lou Zimmerman's infection was
21 entirely consistent with a contaminated probe being
22 inserted into that part of her brain at surgery?
23 MS. DISILVIO: Objection.
24 MR. MALONE: I'm going to object to any
25 questions regarding deposition testimony that's

15

1 not here. If you want to use the transcript of
2 the deposition, you're free to bring anything
3 with you. I don't see the testimony in front
4 of us. I don't recall that being the
5 testimony.
6 Q. I'm going to have you assume he testified to that.
7 First of all, do you remember him testifying to that
8 point?
9 A. No, that I do not.
10 Q. I want you to assume that that was, in fact, his
11 testimony. Do you have any reason to dispute that?
12 A. Yes.
13 Q. And why do you dispute that?
14 A. Why do I dispute that? I think there are probably
15 other likely explanations.
16 Q. Do you believe there's a more likely explanation?
17 A. Definitely.
18 Q. And what is that?
19 A. I think that she had a surgical site infection most
20 likely from her own endogenous flora.
21 Q. Let me break that down, if I can.
22 A. Sure.
23 Q. You would agree that it was a klebsiella oxytoca
24 that was cultured from the wound infection?
25 A. No.

16

1 Q. How am I --
2 A. I believe there was a klebsiella oxytoca and a staph
3 aureus.
4 Q. I'm sorry.
5 A. Yeah.
6 Q. Correct, both. And the klebsiella oxytoca is an
7 enteric organism?
8 A. What do you mean by that?
9 Q. What do you understand an enteric organism to be?
10 A. Only from the gut. I disagree with that.
11 Q. You disagree with that it is an organism that is
12 normally found inside the gut?
13 A. It is an organism that has been well described as
14 having extra-intestinal sources, that is not only of
15 the gut.
16 Q. So you would disagree that it's normally found
17 inside the gut?
18 A. I would agree that it is found in the gut but not
19 exclusively in the gut.
20 Q. Isn't it normally found inside the gut?
21 MS. DISILVIO: Objection. Asked and
22 answered. You can answer that again, Doctor.
23 A. It can be a normal colonizer in the gut.
24 Q. What is the source of that organism?
25 A. Klebsiella is a subset of something called

17

- 1 Enterobacteriaceae, which include a variety of gram
2 negative organism, which is ubiquitous.
3 Q. Where are they typically found in the human body?
4 A. In the human body? The human body it can be in the
5 gut, can be in the skin, can be in the respiratory
6 tract, can also be described from bloodstream
7 infections, **so** there's been an increasing
8 recognition of extra-intestinal nosocomial
9 infections with Enterobacteriaceae.
10 Q. Are you saying that the organism is found -- is
11 actually generated in the skin?
12 A. It can be, yes.
13 Q. How does it actually get to the skin?
14 A. The skin, the organism is ubiquitous, it's found in
15 nature, in soil, in plants. **You** don't have to --
16 it's out there.
17 Q. Tell **me** everything that forms the basis for your
18 opinion that Mrs. Zimmerman's infection was most
19 likely a wound infection that came from her own
20 flora.
21 A. I guess to begin with, the pathogenesis of surgical
22 site infections is complicated and not fully
23 understood. With that as a background, there are
24 probably several things that would make me believe
25 the most likely thing is endogenous flora that is

18

- 1 coming from her own scalp.
2 One, the bugs themselves, klebsiella and staph
3 aureus, can be commonly found on the skin and have
4 been well described as nosocomial surgical site
5 pathogens.
6 Two, the susceptibility of these organisms are
7 very susceptible, not high resistance. This would
8 also support that these were endogenous, not
9 hospital acquired.
10 Three, the bloodstream infection isolates were
11 concomitant with the onset of fever as well as pus
12 from the site, most likely again, common things
13 common, that the surgical site wound was the source
14 for the bacteremia.
15 Four, to hypothesize a contaminated instrument
16 is interesting, but **I** feel **is** militated against **two**
17 main things here. One, is both of these bugs can be
18 found on the skin and cause surgical site
19 infections. Two, is the procedure itself did not
20 lend itself to a multiple amount of
21 instrumentations, that sterilization of these
22 instruments was done. These were not instruments
23 for single use only. Three, is you have **to**
24 postulate not one organism but two organisms, which
25 is very less likely for a common source

19

- 1 contamination.
2 Q. I'm sorry, are you through with your answer?
3 A. **Yes**.
4 Q. What medical literature or publications support your
5 position that klebsiella oxytoca is found on the
6 skin?
7 A. As a nosocomial pathogen, I would go to the National
8 Surveillance Infection Data by CDC **for** surgical site
9 infections broken down by pathogen type.
10 Approximately three to five percent of all surgical
11 site infections are klebsiella, aside from other
12 literature, which I can't cite you now, **but** you
13 could look it up in a clinical microbiology book, I
14 suppose.
15 Q. Can you name those, please?
16 A. Probably Murray's Manual, Clinical Microbiology.
17 Q. What else?
18 A. I think that's probably enough. **I'm** sure Mandell
19 and Bennett, as well, in their chapters on
20 klebsiella would talk about extra-intestinal issues
21 with klebsiella.
22 Q. Nosocomial means hospital acquired?
23 A. Right, correct.
24 Q. Endogenous means it comes from the patient?
25 A. Correct.

20

- 1 Q. While she's in the hospital, it's an endogenous
2 nosocomial organism?
3 A. Endogenous is more where the source of the organism
4 is. Nosocomial is where it's acquired.
5 Q. The source of the organism being from the **patient's**
6 own body?
7 A. Correct.
8 Q. And you're saying in this case on the skin?
9 A. Yes, probably.
10 Q. Skin or hair?
11 A. Skin, hair, scalp, any or all.
12 Q. And how did that organism get to the skin, the scalp
13 **or** the hair?
14 A. It could be a normal colonizer, **just** like staph
15 aureus.
16 Q. Isn't it an unusual organism to find in a
17 postsurgical infection?
18 A. No.
19 Q. Well, what percentage of cases at The Cleveland
20 Clinic would have that organism as opposed to other
21 organisms?
22 A. Well, we don't do a hundred percent surveillance, **so**
23 I can't tell you what the whole number would be.
24 Q. Of the ones you do survey, what percentage?
25 A. Probably about five percent.

21

- 1 Q. And the numbers that you do survey, what percentage
2 are staph infections?
3 A. Staph infections, probably closer to 20 to 30
4 percent.
5 Q. And how about strep?
6 A. Strep, it would be farther down.
7 Q. Would it be as low as five percent?
8 A. I couldn't tell you that offhand.
9 Q. So help me out, because I'm not an epidemiologist.
10 What's your ultimate opinion as to how she got this
11 infection?
12 A. The pathogenesis of this, I can't tell you a hundred
13 percent.
14 Q. Can you tell me with any sort of reasonable
15 probability?
16 A. The most likely etiology of this is that she was
17 colonized with these organisms, scalp, hair, head,
18 whatever, that during the procedure that is when the
19 inoculation occurred into the surgical site, and
20 that was the genesis 14 days later.
21 Q. Colonization, what do you mean by that?
22 A. None of us are sterile. We're all colonized with
23 bacteria.
24 Q. Does that bacteria -- how does that bacteria get on
25 her scalp, skin or hair?

22

- 1 A. It lives there. It's part of this -- we shed our
2 skin, our skin turns over, there's oils. It's a
3 normal part of who we are.
4 Q. And how does that get -- is it your opinion that the
5 surface wound infection then led to the brain
6 abscess and the bacteremia?
7 A. The surface -- help me out.
8 Q. Sure. We know that she has a surface wound
9 infection.
10 A. A surgical site infection.
11 Q. I'm sorry, wrong choice. Surgical site infection.
12 A. Correct.
13 Q. Which may, if you believe the discharge summary,
14 include a deep organ space infection, correct?
15 A. Correct.
16 Q. She also had a resulting bacteremia?
17 A. Correct.
18 Q. Which is a bloodstream infection?
19 A. Correct.
20 Q. And do you believe that the brain abscess, assuming
21 it was there, and the blood infection resulted from
22 the surgical site infection?
23 A. I believe that the surgical site infection caused a
24 secondary bloodstream infection.
25 Q. And if, in fact, an abscess was there -- strike

23

- 1 that.
2 Assuming that an abscess is there, would you
3 believe that it most likely would have the same
4 organisms as the surface wound?
5 A. Probably. I wouldn't be surprised.
6 Q. And assuming that there is a brain abscess, you
7 believe that would be secondary to the surgical
8 wound infection --
9 MS. DISILVIO: Objection.
10 Q. -- as opposed to the brain abscess working its way
11 out to the surface wound?
12 A. Correct.
13 Q. Let me just restate that to make sure we're on the
14 same page.
15 A. Okay.
16 MS. DISILVIO: Do you want to use
17 surgical site infection so I don't keep
18 objecting?
19 MR. LINTON: That's fine.
20 Q. The surgical site infection includes both the
21 surgical wound as well as the brain abscess?
22 A. Let's -- the surgical site infection, it was a
23 result of the surgical wound at the time of her
24 cingulotomies.
25 Q. All right. In other words, the surface wound is

24

- 1 infected first, which then leads to a bloodstream
2 infection and a brain abscess?
3 A. But remember her surgery is not -- it's a --
4 Q. It's a probe in the brain.
5 A. It's a probe down there, so there's a track there.
6 Q. My question to you is does the brain infection track
7 up to the surface, or does the surface track down to
8 the brain, or do you not know?
9 A. I couldn't tell you that.
10 Q. Now, getting back to your claim that the organism
11 would have been on her scalp, her skin or her hair,
12 you believe it just lived there as opposed to being
13 placed there by maybe not washing her hands
14 properly, or it's just there on the skin, that's
15 what you're saying?
16 MS. DISILVIO: Objection. Asked and
17 answered. You may answer again.
18 MR. LINTON: I'm laying a foundation to
19 my question.
20 Q. I mean, do you understand?
21 A. My understanding is staph aureus and klebsiella
22 oxytoca are in the skin.
23 Q. They live there anyway?
24 A. It would not surprise me if it's on the scalp in
25 that area, no.

25

- 1 Q. Is it always present on everybody's scalp and
 2 everybody's skin and everybody's hair?
 3 A. I can't tell you that.
 4 Q. Why not?
 5 A. I don't think that study has been done.
 6 MR. MALONE: We could culture **you**, Bob,
 7 if you want.
 8 Q. Are there any studies that have cultured populations
 9 to establish if this is an organism routinely found
 10 on the skin?
 11 A. Probably, but I can't quote them.
 12 Q. Now, **so** we've got this bug.
 13 A. Bugs.
 14 Q. Bugs, plural, that are in her hair, on her scalp and
 15 her skin, right, that's your theory. I'm going to
 16 butcher the pronunciation, but the
 17 Enterobacteriaceae?
 18 A. Enterobacteriaceae.
 19 Q. What does that mean?
 20 A. That's kind of -- as you know we like to use terms
 21 genus species, families, tribes, **so**
 22 Enterobacteriaceae would include the genus
 23 klebsiella but would also include other gram
 24 negatives, usually modal organisms, E-coli,
 25 Shigella, Salmonella, **so** most of these, you know,

26

- 1 this was before they had molecular typing, are done
 2 by clinical characteristics, they were at the time,
 3 in terms of specie-ing, **so** it's a kind of a club.
 4 Q. Does the definition say anything about the location
 5 of the organism in the human body?
 6 A. **No**.
 7 Q. How do these bugs get from Mary Lou Zimmerman's hair
 8 or scalp or skin into the wound and into the brain?
 9 A. Well, as you know, whenever there is a surgical
 10 wound made the integrity-- not integrity is broken,
 11 there's skin broken, the barrier. Your best barrier
 12 for defense for wound infection is broken. The
 13 pathogenesis, the simplest explanation, the one most
 14 of **us** adhere to, is there is a certain inoculum that
 15 **is** always going to be put into the wound. That
 16 would be the pathogenesis.
 17 Q. And aren't these bugs eliminated with the proper
 18 Betadine scrub and prep?
 19 A. **The** answer to that would **be** no. What we try to do
 20 is decrease risk for any type of procedure, and it
 21 is thought, again, that that would help reduce the
 22 microbial load but certainly is not going to
 23 eradicate it.
 24 Q. **You** talked about you think this is the most likely
 25 explanation for her infection, correct?

27

- 1 A. **Can we** --
 2 Q. Yes, let me summarize that. Reiterate for me your
 3 most likely explanation for her infection.
 4 A. Nosocomial surgical site infection, secondary
 5 bloodstream infection, polymicrobial source
 6 endogenous flora.
 7 Q. You cannot rule out, however, the possibility --
 8 A. Of course not.
 9 Q. -- **that** it could be a contaminated probe, correct?
 10 A. Of course not.
 11 Q. What about her clinical picture, if anything, is
 12 inconsistent with her being contaminated by a probe
 13 during surgery?
 14 A. It goes back to some of the things I said, two bugs
 15 contamination versus one. **It's** kind of a stretch.
 16 Susceptibilities **of** those bugs don't really imply a
 17 hospital acquired bug, alternative explanation, more
 18 likely explanation, I think, available, and no
 19 clustering **of** any other cases similar to hers after
 20 probe surgery, that we're aware **of**.
 21 Q. Are you able to -- how do **you** know that?
 22 A. From our surgical site surveillance.
 23 Q. Are you able to say that there were no other
 24 neurosurgical probe surgeries involving this
 25 organism, klebsiella oxytoca?

28

- 1 A. Not that we're aware **of**.
 2 - - - -
 3 (Thereupon, Plaintiffs' Gordon Exhibit
 4 2 was mark'd for purposes **of** identification.)
 5 - - - -
 6 Q. Handing you what's been marked as Exhibit 2, which
 7 is a letter we received from The Cleveland Clinic's
 8 law firm identifying surgical patients with
 9 postoperative klebsiella oxytoca infections.
 10 First of all, have you seen that before I just
 11 handed it **to** you?
 12 A. **No**.
 13 Q. Are you aware of the data contained in that letter,
 14 specifically the neurosurgery listed as number six,
 15 nine and ten?
 16 A. Specific -- I'm sorry?
 17 MS. DISILVIO Why don't **you** give him a
 18 minute to read it and look at it, and I'm sure
 19 he can answer your question better.
 20 A. You're asking me if I'm aware of other klebsiella
 21 oxytoca infections of a clean site in other surgical
 22 situations from 1998 **on**?
 23 Q. What records have you reviewed to confirm there were
 24 no other neurosurgical procedures involving a probe
 25 that resulted in a klebsiella oxytoca infection?

29

- 1 A. I guess that goes with surveillance. We do
2 prospective surveillance, we rely on admission
3 cultures, communications with all our neurosurgeons
4 usually on a monthly basis. So is that a hundred
5 percent, no. But is it what we've been doing for
6 the past two to three years, yes. Has that changed,
7 no. Point being, we do surveillance.
- 8 Q. Have you testified in any other cases for the
9 Cleveland Clinic where there's been an allegation of
10 a problem with an infection?
- 11 A. Testified in court?
- 12 Q. Or deposition.
- 13 MS. DISILVIO: What do **you** mean by
14 problem with infection; an infectious disease
15 case or an epidemiology case?
- 16 MR. LINTON: Either one.
- 17 A. I've testified on an infectious disease case that
18 was personally involved with as a treating
19 physician.
- 20 Q. What was the issue in that case?
- 21 A. The issue was --
- 22 MS. DISILVIO: Actually, I think Mark
23 can tell you about it. I think it was Linda
24 Coberly versus The Cleveland Clinic Foundation,
25 and I think Toby took the deposition.

30

- 1 A. I'm not aware of the specifics, but I'm sure someone
2 has records of it.
- 3 Q. What was the issue, the infection in that case?
- 4 A. The infection for that case, I believe, was
5 coccidiomycosis.
- 6 Q. Any other case in which you've testified, either by
7 deposition or trial?
- 8 A. Certainly not at trial. These are such memorable
9 experiences that I should --
- 10 Q. One would think.
- 11 A. But there might have been another one --
- 12 MS. DISILVIO: Don't guess. Only if
13 you remember.
- 14 A. Wait a minute. There was one other one, yes.
- 15 Q. What was it?
- 16 A. The issue there was postoperative aspiration
17 pneumonia.
- 18 MS. DISILVIO: That's Linda Coberly.
- 19 THE WITNESS: Is that the Dr. Rice
20 case?
- 21 MS. DISILVIO: Yes.
- 22 Q. What was the issue in --
- 23 A. That's the cocci case, coccidiomycosis.
- 24 Q. Just the one?
- 25 A. And the Linda Coberly case and this case.

31

- 1 Q. I asked you a moment ago whether -- strike that.
2 Is there anything about Mary Lou Zimmerman's
3 clinical picture that is inconsistent with a
4 contaminated probe in terms of --
- 5 A. Yes.
- 6 Q. What specifically about her clinical picture?
- 7 A. Again --
- 8 MS. DISILVIO: Objection. Asked and
9 answered. You may answer it again.
- 10 A. Oh, yes, okay. What militates against it are the
11 things that I've already mentioned, the organisms,
12 the clinical situation, the fact that you've got
13 more than one, the fact that we don't have any other
14 epidemiologic evidence to suggest a contaminated
15 probe with other cases.
- 16 Q. I'm not asking the question properly. Is there
17 anything about her clinical presentation and the way
18 that she developed the infection that is
19 inconsistent with it being a contaminated probe?
- 20 A. I still don't -- I still don't understand.
- 21 MR. MALONE: He's answered your
22 question a couple times.
- 23 MR. LINTON: No, he hasn't. I'm not
24 asking it properly.
- 25 A. Okay.

32

- 1 Q. What was the first sign or symptom of Mary Lou
2 Zimmerman's infection?
- 3 A. I think that's hard to answer retrospectively. What
4 prompted her blood cultures and wound culture was
5 drainage and fever on post-op day 12 or 13.
- 6 Q. October 4th?
- 7 A. If that's what it was.
- 8 Q. And are those presenting signs inconsistent with her
9 having a brain abscess due to a contaminated probe?
- 10 A. They're not inconsistent with a surgical site
11 infection.
- 12 Q. Are they inconsistent with her having an abscess
13 that was caused by a contaminated probe being
14 inserted during her right craniotomy?
- 15 A. I have no experience with that. In other words,
16 I've never been involved with a case where there's
17 been a contaminated probe, that I'm aware of, so I
18 can't answer that question.
- 19 Q. Have you ever been involved in any case where
20 there's been a contaminated instrument that's caused
21 the infection?
- 22 A. No, no.
- 23 Q. Are you aware of any report of that anywhere in the
24 literature?
- 25 A. Yes.

33

- 1 Q. Are surgical instruments routinely tested at The
2 Cleveland Clinic after surgery to see if they're
3 contaminated?
4 A. I'm sorry?
5 Q. When a surgery is performed at the Cleveland Clinic
6 there are instruments used during that surgery,
7 correct?
8 A. Correct.
9 Q. Is there any testing done on a routine basis to see
10 whether the instruments that were used during a
11 surgery were contaminated?
12 A. I still don't understand.
13 Q. Was there any testing of this probe done following
14 Dr. Barnett's surgery?
15 A. I don't know the answer to that.
16 Q. And without testing of that, you can't rule out the
17 possibility that the probe was, in fact,
18 contaminated, can you?
19 A. Without testing after the surgery?
20 Q. Correct.
21 A. I would say I can't -- that wouldn't help me.
22 MR. MALONE: Common sense tells you
23 that wouldn't help at all.
24 A. The probe has been inserted in a body cavity.
25 Q. But the brain is sterile?

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- 1 A. Yeah, but not a brain exposed to air or that just
2 had some endogenous flora punched into it.
3 Q. From a hospital epidemiology standpoint, are you any
4 more concerned when a surgical site infection is
5 positive for a klebsiella oxytoca as opposed to a
6 staph infection?
7 A. As an epidemiologist I guess we're concerned about
8 all types of infection.
9 Q. Does the fact that is an enteric organism, like a
10 klebsiella oxytoca, cause you any more concern as
11 opposed to a staph infection?
12 A. I guess I would disagree that it's always an enteric
13 organism.
14 MR. LINTON: Can you read that back,
15 please.
16 - - -
17 (Thereupon, the requested portion of
18 the record was read by the Notary.)
19 - - -
20 Q. You would agree though that it's typically
21 classified in the medical literature as an enteric
22 organism?
23 A. No, I guess what I would agree to is
24 extra-intestinal manifestation of klebsiella are
25 recognized as such.

35

- 1 Q. But isn't it typically referred to in the medical
2 literature as an enteric organism?
3 A. Not as a nosocomial surgical site infection it is
4 not.
5 Q. But it is typically referred to as an enteric
6 organism in terms of the klebsiella oxytoca?
7 MS. DISILVIO: Objection.
8 A. I don't know that.
9 Q. Is it as commonly found on the skin as it is in the
10 gut?
11 A. Don't know that either.
12 Q. Is there any medical literature to support one way
13 or the other?
14 A. One way or the --
15 Q. That it's more common to the gut or more common to
16 the scalp?
17 A. I don't know that.
18 Q. Or the skin?
19 A. I don't know that.
20 Q. So getting back to the question about you as a
21 hospital epidemiologist, you would be no more
22 concerned about a klebsiella oxytoca as a surgical
23 site infection than you would as a staph infection?
24 A. It would depend on the circumstances.
25 Q. Okay. Under what circumstances would it be more of

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- 1 a concern to you?
2 A. It would depend on the entire case. But five
3 percent of our surgical site infections are
4 klebsiella, and those are post-op nosocomial
5 infections. So if you're asking me if I had one
6 case would that engender a sentinel investigation,
7 no.
8 Q. So it is an acceptable risk here at The Cleveland
9 Clinic to have a klebsiella oxytoca surgical site
10 infection?
11 MS. DISILVIO: Objection.
12 A. I don't know what's acceptable and what's not. I
13 think surgical site infections are a risk of any
14 surgical procedure done anywhere.
15 Q. Well, as a hospital epidemiologist do you have an
16 acceptable rate of infections here at the Clinic?
17 A. I'm not in a position to comment on that.
18 Q. Why not?
19 A. My goal, quite frankly, is to try to reduce the risk
20 of surgical site infections and other infections or
21 other complications when possible. We don't
22 benchmark to say what's acceptable and what's not.
23 In certain circumstances one infection might be
24 unacceptable.
25 Q. But in Mary Lou Zimmerman's case it was acceptable?

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- 1 MS. DISILVIO: Oh, objection.
 2 A. Acceptable --
 3 MR. MALONE: I'm going to object. He
 4 hasn't used the word acceptable. The only one
 5 using that word is you, Mr. Linton.
 6 Q. Do you believe it's acceptable, coming from a
 7 hospital epidemiologist?
 8 A. What do you mean by acceptable?
 9 Q. What does it mean?
 10 A. I'm asking you.
 11 Q. I'm asking you what you think it means.
 12 MR. MALONE: You're the only one that
 13 used the term.
 14 Q. You don't know what acceptable means?
 15 A. Not in this context, no. What does that mean, that
 16 her wound infection is acceptable?
 17 Q. Well, were any steps taken to make sure that doesn't
 18 happen in future cases?
 19 A. I guess any steps taken, I still don't know what you
 20 mean by that.
 21 Q. Any, do you know what the word any means?
 22 A. Correct.
 23 Q. Steps?
 24 A. Correct.
 25 Q. Taken?

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- 1 MS. DISILVIO: Bob, with all due
 2 respect, if you're going to talk to Dr. Gordon
 3 like that we're going to end the deposition
 4 right now.
 5 MR. LINTON: No, no, I'm asking the
 6 doctor a simple question. You can do whatever
 7 you want to do, Marilena.
 8 MS. DISILVIO: You're not going to
 9 raise your voice with me either.
 10 MR. LINTON: You can do whatever you
 11 want to do, Marilena. I'm asking the doctor
 12 about some simple words.
 13 Q. Any steps taken, what part of those three words
 14 don't you understand?
 15 MS. DISILVIO: At this point we're
 16 going to terminate the deposition.
 17 A. I don't understand what that means.
 18 MR. LINTON: Fine, we're done. We're
 19 going to terminate it?
 20 MR. MALONE: You said we're done.
 21 MR. LINTON: She said she's terminating
 22 the deposition,
 23 MR. MALONE: You said you're done.
 24 MR. LINTON: Are you terminating it or
 25 not?

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- 1 MS. DISILVIO: I want you, Bob, to
 2 treat the doctor with respect.
 3 MR. LINTON: I am treating him entirely
 4 with respect.
 5 MS. DISILVIO: You're raising your
 6 voice and treating him like he's three years
 7 old.
 8 Q. Is my voice raised, Doctor?
 9 A. No.
 10 MS. DISILVIO: Asked me and I will tell
 11 you if it's raised.
 12 MR. LINTON: If you want to object,
 13 that's fine, but you said you were going to
 14 terminate the deposition.
 15 A. I guess I don't understand any steps.
 16 MS. DISILVIO: Let me interject. At
 17 the beginning of this deposition, Mr. Linton,
 18 you very graciously told Dr. Gordon --
 19 MR. LINTON: I don't need a speech,
 20 Marilena.
 21 MS. DISILVIO: Hey.
 22 MR. MALONE: Let her finish.
 23 MR. LINTON: I'm asking what steps were
 24 taken.
 25 Q. What part of any steps --

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- 1 MR. MALONE: Don't respond.
 2 Q. What part of any steps taken don't you understand?
 3 MS. DISILVIO: At the beginning of the
 4 deposition --
 5 MR. LINTON: We're done.
 6 MS. DISILVIO: --you advised the
 7 deponent if he couldn't answer a question, if
 8 he misunderstood it, Mr. Linton's question, you
 9 would be happy to rephrase the question.
 10 Dr. Gordon has told him that he doesn't
 11 understand in this particular context what the
 12 question references. Now, having said that,
 13 you can either rephrase the question or you can
 14 elect to terminate this deposition.
 15 MR. LINTON: You were the one who
 16 terminated it.
 17 Q. I'm going to ask you again, Doctor. What part of
 18 any steps taken don't you understand?
 19 A. Any steps taken --
 20 Q. To make sure this infection doesn't happen again to
 21 future patients at The Cleveland Clinic.
 22 A. We cannot assure any patient is not going to get an
 23 infection in the Cleveland Clinic. It's part of a
 24 surgical site infection.
 25 Q. What is the rate for surgical site infections here

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1 at the Cleveland Clinic?
 2 A. We don't do overall surgical site infection rates.
 3 Q. What is the rate for neurosurgical procedures?
 4 A. Approximately four in a hundred procedures.
 5 Q. And has that increased, decreased or stayed the same
 6 since you took over?
 7 A. It fluctuates.
 8 Q. I take it by your answer that means it has both
 9 increased and decreased and stayed the same?
 10 A. Correct.
 11 Q. What was the highest point during the time in which
 12 you were chairman of that committee?
 13 A. I can't tell you that offhand.
 14 Q. What is the lowest point?
 15 A. I can't tell you that offhand either.
 16 Q. What steps have been taken to lower the rate of
 17 surgical site infections for neurosurgery
 18 procedures?
 19 A. I guess, generally speaking, the biggest steps I
 20 think that are taken here is communication with our
 21 neurosurgeons. We're very fortunate, in my opinion,
 22 in that Mary and I, I think, have a very good
 23 relationship with the surgeons.
 24 They report any suspected infections to us,
 25 they get their op reports, we would investigate

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1 those, we trend them. If we see trends, we are
 2 either asked or we initiate investigations or
 3 inquiries. This has been done several times in the
 4 past and continues. It's a dialogue. I've been up
 5 into the neurosurgical suite, Mary has been in the
 6 neurosurgical suite. Our goal here is to reduce the
 7 risk of any adverse outcome.
 8 Q. How many of these sort of infections have to occur
 9 before there is a trend or a cluster? And let me
 10 begin by saying is there a distinction in your mind
 11 between a cluster and a trend?
 12 A. I think so.
 13 Q. How would you define those?
 14 A. I think the issue becomes not just a numerator
 15 issue, it's a denominator issue. If you're doing
 16 something that is relatively unusual, and these
 17 cases are not that common, it's extremely hard to
 18 track trends up or down.
 19 If you're doing something very frequently, it's
 20 a lot easier then to detect changes or no changes,
 21 so you're limited by the specific frequency of the
 22 procedure that's being done.
 23 Q. What have you done to prepare you to testify today
 24 there has been no trend or no cluster concerning
 25 klebsiella oxytoca infections at The Cleveland

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1 Clinic?
 2 A. Again, we talk frequently, Mary, reviewed our
 3 surgical site infections for neurosurgery, as I do
 4 with the other subsets, and we reviewed the issue of
 5 klebsiella nosocomial bloodstream infections or
 6 after surgical site infections. So, yes, we wanted
 7 to be sure, as much as we could be sure, that there
 8 was no unusual epidemiologic cluster to support the
 9 hypothesis of a contaminated probe.
 10 Q. Are you talking specifically in connection with this
 11 case?
 12 A. No, in general.
 13 Q. You mentioned --
 14 A. In this case, too, I wanted to see that to reconfirm
 15 any trends in klebsiella after a surgical site
 16 infection in neurosurgery.
 17 Q. What did you do to reconfirm that?
 18 A. We reviewed all the cases from '98 on and looked at
 19 our rates.
 20 Q. And what were your rates from '98 on?
 21 A. Again, around about four per hundred procedures.
 22 This specific procedure, this was the only case that
 23 we could find.
 24 Q. Do you know if any of the other four cases out of a
 25 hundred involved Dr. Barnett?

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1 A. You mean four out of a hundred procedures? I would
 2 have to say offhand, yes, he's probably one of our
 3 busier surgeons.
 4 MR. MALONE: Dr. Gordon, I sense a
 5 misunderstanding. When you say four out of a
 6 hundred, are you saying there have only been
 7 one hundred neurosurgical procedures?
 8 THE WITNESS: That's a rate.
 9 MR. LINTON: With all due respect --
 10 MR. MALONE: I could tell you were
 11 missing it. I thought you understood him to
 12 mean a hundred cases and four had been
 13 infected. He's quoting a four percent rate,
 14 four out of a hundred. There have clearly been
 15 more than a hundred surgeries.
 16 MR. LINTON: I understood that.
 17 MR. MALONE: Then excuse my
 18 interruption.
 19 - - -
 20 (Thereupon, a discussion was had off
 21 the record.)
 22 - - -
 23 Q. Have you had any other klebsiella oxytoca infections
 24 after a stereotactic procedure, besides this one?
 25 A. Not that I'm aware of.

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- 1 Q. Any staph infection cases after a stereotactic
 2 procedure?
 3 A. Not that I'm aware of, no.
 4 Q. I want to be clear. When you say not that you're
 5 aware of, might there be records of such cases that
 6 you simply can't recall at this time?
 7 A. No, I think it would require reviewing the
 8 surgical -- I mean, specific surgical codes. I
 9 mean, we have the data.
 10 Q. What data do you have to make that calculation or
 11 determination?
 12 A. We have a list of all our nosocomial surgical site
 13 infections after clean neurosurgical procedures.
 14 Q. What information is contained in that data?
 15 A. Probably surgeon, patient identifier, pathogen.
 16 - - - -
 17 (Thereupon, Plaintiffs' Gordon Exhibit
 18 3 was mark'd for purposes of identification.)
 19 - - - -
 20 Q. I'm marking as Exhibit 3 the Clinic's responses to
 21 our request for production of documents, and I'd
 22 like you to take a look at the last two pages on
 23 that, if you would, Doctor.
 24 A. Okay.
 25 Q. First of all, do you recognize that? It's entitled

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- 1 Standard Report.
 2 A. It certainly could be a Standard Report coming from
 3 our database.
 4 Q. It's not from your database?
 5 A. I said it could be from our database. We generally
 6 look at the data differently, but this is a line
 7 listing.
 8 Q. And the information, if you could help me out here,
 9 the top, last, obviously is last name, we have
 10 Zimmerman?
 11 A. So you're looking at the last page now?
 12 Q. This page right here.
 13 A. Yes.
 14 Q. MRN, is that an identifying number?
 15 A. Medical Record Number.
 16 Q. Onset is?
 17 A. Onset of the nosocomial infection.
 18 Q. Okay. Source?
 19 A. Source, if it could be identified, coded, whether
 20 it's considered to be primary bloodstream, wound,
 21 urine.
 22 Q. What does F3 mean?
 23 A. The codes, I see them without the codes.
 24 Q. So you don't know what source F3 means?
 25 A. Not offhand, no.

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- 1 Q. Where would one have to look to see what the source
 2 code is to see what an F3 means?
 3 A. I mean, all I have to do is talk to one of the
 4 ICPS. It's not a state secret.
 5 Q. Specific site means?
 6 A. Specific site, again, would be the specific site
 7 from which the infection occurred.
 8 Q. Okay. What is the significance of the word
 9 bacteremia?
 10 A. That's a bloodstream infection with a bacteria.
 11 Q. And why is that listed as a specific site for Mary
 12 Lou Zimmerman's infection?
 13 A. Why is it or isn't it?
 14 Q. It is.
 15 A. This is?
 16 Q. I'm sorry, Doctor, we're looking at the wrong --
 17 forgive me. You're looking at the last page?
 18 A. Right.
 19 Q. We've got surgical date, the general description is
 20 obviously the department, the staff code. Is that
 21 the specific surgeon?
 22 A. It should be, yes.
 23 Q. Specific description, organ/space, path code 248.
 24 Does that mean klebsiella oxytoca?
 25 A. Correct.

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- 1 Q. If you could go, please, two pages before that.
 2 A. Okay, yeah, here.
 3 Q. What does -- again, we have Zimmerman?
 4 A. Right.
 5 Q. We've got her number, we've got the onset, the
 6 source there, F3. What would that stand for?
 7 A. Probably secondary to the surgical site infection.
 8 We track all nosocomial bacteremias.
 9 Q. Okay. How is that input entered? I mean, who
 10 actually inputs that?
 11 A. The infection control nurse would make his or her
 12 assessment, questions would be talked about if
 13 there's a question, and then make the epidemiologic
 14 determination as best they can.
 15 Q. And what does spec. site mean?
 16 A. Specific site.
 17 Q. And what does that mean?
 18 A. That's, again, where the pathogen was isolated
 19 from.
 20 Q. And what's the significance of bacteremia under Mary
 21 Lou Zimmerman?
 22 A. She had a nosocomial bacteremia.
 23 Q. Looking back at Exhibit, is that, 2?
 24 A. 2.
 25 Q. Looking at the klebsiella oxytoca cases reported as

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- 1 listed in that document, that would not constitute a
 2 trend or a cluster that would concern you as the
 3 hospital epidemiologist?
 4 A. You mean presented with this?
 5 Q. Yes.
 6 A. **No.**
 7 Q. And why not?
 8 A. I have no denominator data here.
 9 Q. And the denominator data would be the number of
 10 procedures performed?
 11 A. Correct.
 12 Q. What would be the rate at which you would become
 13 concerned and consider it to be either a cluster or
 14 a trend?
 15 A. It would, again, depend upon the specific procedures
 16 and the issue.
 17 Q. Assuming that the normal rate is four out of a
 18 hundred or four percent?
 19 A. Not for klebsiella.
 20 Q. Klebsiella is five percent?
 21 A. What's that?
 22 Q. Klebsiella is five percent?
 23 A. Depends which site we're talking about. Nosocomial
 24 bacteremia, surgical site infections, I mean,
 25 there's more to it.

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- 1 Q. What is the rate for klebsiella oxytoca with
 2 surgical site infections at The Cleveland Clinic?
 3 A. I don't have that number.
 4 Q. Would you --
 5 A. We do not do total surgical site surveillance.
 6 Q. I want to try to understand the math. The current
 7 rate for neurosurgical site infections is about four
 8 percent?
 9 A. For clean neurosurgical site infections.
 10 Q. What do you mean by a clean surgical site?
 11 A. Those that are not dirty coming in, it's not a
 12 trauma case, not a transfer from another hospital
 13 where they've been instrumented.
 14 Q. Mary Lou Zimmerman's case would be a clean case?
 15 A. Right.
 16 Q. So if it's a four percent rate you would expect five
 17 percent of that four percent to have a klebsiella
 18 oxytoca organism?
 19 A. Again, I don't think it's that simple for procedures
 20 that are new, for procedures done with little
 21 frequency. **No** one's got that number.
 22 Q. So you don't have a number on the infection rate for
 23 stereotactic procedures?
 24 A. Right. For instance, I'm not aware of any numbers
 25 published for anterior cingulotomy infections from a

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- 1 probe.
 2 Q. Well, then at what point would you become concerned
 3 as a hospital epidemiologist not having a database
 4 to look at?
 5 A. If we saw any clustering of cases.
 6 Q. Any clustering being more than one?
 7 A. In this particular circumstance, if it's a low
 8 frequency procedure, that might generate at least a
 9 query.
 10 Q. We can agree that a cingulotomy is a relatively
 11 infrequent procedure here at the Cleveland Clinic?
 12 A. I'm not certain about that. **I just** don't think
 13 it's -- I mean, from Dr. Barnett's testimony, I
 14 don't think we do a lot of them.
 15 Q. He said he's done three to four a year. That's not
 16 a lot, is it?
 17 A. I don't know how many are done worldwide. For all I
 18 know, that's the most done in Ohio.
 19 Q. I'm sure it is.
 20 A. You know, I mean, I don't know. I don't know about
 21 a data -- specific database for that.
 22 Q. Do you know the infection rate in any other
 23 institutions that are doing this type of procedure?
 24 A. **I do not.**
 25 Q. Assuming there were less than five of these

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- 1 procedures being done a year and there were two
 2 reported cases of a klebsiella oxytoca surgical site
 3 infection, would that be enough to concern you as a
 4 hospital epidemiologist?
 5 A. I would be concerned. **I** think I would be
 6 concerned. I would be concerned about any low
 7 frequency procedure where --
 8 Q. There was more than one?
 9 A. Well, where maybe there's not enough information,
 10 you know.
 11 Q. Are all surgical site infections monitored at the
 12 Clinic?
 13 A. No. There are 38,000 procedures a year.
 14 **MR. MALONE:** He's actually answered
 15 that, I think, about six times.
 16 A. No.
 17 Q. What percentage of the 38,000 a year are actually
 18 monitored?
 19 A. Oh, gosh, **I** don't know exactly.
 20 Q. Approximately.
 21 A. Maybe nine to ten that, you know, we do targeted
 22 surveillance, nine to ten thousand.
 23 Q. **So** there may be other cingulotomy surgical site
 24 infection cases that have occurred here at the
 25 Cleveland Clinic that you might be unaware of

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- 1 through your surveillance?
- 2 A. No, neurosurgical clean sites are targeted.
- 3 Q. But not every case?
- 4 A. No, every case would be, every clean surgical case
- 5 would be. ~~Is~~ it possible that the surveillance is
- 6 not a hundred percent, yes, but that's not a blind
- 7 spot on paper for us.
- 8 Q. I misunderstood something. You said 38,000
- 9 procedures, roughly eight to nine thousand of those
- 10 are surveyed?
- 11 A. Right, but it's targeted surveillance, it's not
- 12 random.
- 13 Q. What do you mean by random?
- 14 A. Cardiothoracic, neurosurgical, clean, orthopedic
- 15 implantation, spine surgeries.
- 16 Q. So all neurosurgical clean sites are monitored?
- 17 A. Yes, we have an active surveillance system for
- 18 those.
- 19 Q. For all those procedures?
- 20 A. For all those procedures.
- 21 Q. Have there been any other infections involving
- 22 stereotactic procedures here at the Clinic besides
- 23 Mary Lou Zimmerman?
- 24 MS. DISILVIO: Surgical site?
- 25 Q. Involving any type of organism.

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- 1 MR. MALONE: Including any type of
- 2 stereotactic procedure?
- 3 A. I would have to say yes, but I can't, you know, I
- 4 would be surprised if there's not, given the volume,
- 5 but I can't give you an exact number on that.
- 6 Q. Well, as part of your investigation in this case,
- 7 you said you reviewed the other cases of
- 8 stereotactic procedures?
- 9 A. No.
- 10 Q. I'm sorry, I misunderstood.
- 11 A. We reviewed all our infection surgical site data in
- 12 patients undergoing neurosurgical procedures at the
- 13 Clinic since 1998.
- 14 Q. And how many klebsiella oxytoca infections were
- 15 there?
- 16 A. I would -- klebsiella oxytoca probably represented
- 17 approximately five percent of those that had a
- 18 pathogen culture.
- 19 Q. Were those limited to surgical site infections?
- 20 A. Yes, yes.
- 21 Q. Do you know what is required to properly sterilize
- 22 the surgical field before performing this type of
- 23 surgery on Mary Lou Zimmerman?
- 24 A. My understanding is the surgical field is never
- 25 sterile.

55

- 1 Q. Well, what is done to prep it to try to make it
- 2 sterile?
- 3 A. I could give you generalities, but specifics you'd
- 4 probably have to ask Dr. Barnett and the team up
- 5 there.
- 6 Q. What are the generalities, as you understand it?
- 7 A. The generalities would be you want a clean surface,
- 8 you want to put a topical, you know, a Betadine type
- 9 solution, you want to rub, shave, potentially,
- 10 depending on where it goes, let things dry, put your
- 11 field down and go.
- 12 Q. Is there a -- and you do that obviously to try to
- 13 reduce or prevent an infection?
- 14 A. Right. The object is that --
- 15 Q. You're trying to kill the bugs?
- 16 A. Well, you're not trying to kill the bugs, you're
- 17 just trying to reduce infectious sequelae. You're
- 18 not out there to -- you don't want to throw out the
- 19 baby with the bath water, but you want to do what
- 20 you can to reduce an infectious outcome.
- 21 Q. Well, isn't it reduced by killing the bugs, or at
- 22 least as many as you can?
- 23 A. Well, I mean, you try to reduce any potential
- 24 microbial load, I suppose, but the pathogenesis is
- 25 very complex.

56

- 1 Q. This klebsiella, according to your claim that it's
- 2 on her scalp or hair or skin, are you able to say
- 3 which is the more likely source, hair, scalp, skin?
- 4 A. With a klebsiella and the staph aureus?
- 5 Q. Yes.
- 6 A. Skin.
- 7 Q. Skin or scalp?
- 8 A. Skin or scalp, I would say.
- 9 Q. More likely than hair?
- 10 A. I don't know that.
- 11 Q. You can't say which is more likely, hair or scalp?
- 12 A. Or scalp, yeah.
- 13 Q. Why is it that the surgeon or the surgical assistant
- 14 shaves the head in the area at which they are going
- 15 to be inserting the probe?
- 16 A. It could be a variety of reasons. One is just
- 17 better visualization.
- 18 Q. From an infection control standpoint, what reason?
- 19 A. Well, shaving is actually controversial in terms of
- 20 that. You know, in fact, there have been reports
- 21 where shaving has led to increased infections in
- 22 terms of surgical site.
- 23 Q. Have there been procedures here at the Clinic in
- 24 light of those studies?
- 25 A. Changes? I'm sorry.

57

- 1 Q. In terms of shaving or shaving less.
 2 A. I think for us the shaving and not saving issue is
 3 the surgical domain. If patients are going to be
 4 shaved, we like to have them shaved the day of
 5 surgery, hopefully in the preoperative area as
 6 opposed to the night before.
 7 Q. And why is that?
 8 A. Well, a lot of trauma, and then that might lead to
 9 increased polymicrobial load, so if there's an
 10 overnight delay, theoretically, again, more
 11 organisms might be introduced endogenously with the
 12 scalpel.
 13 MR. LINTON: Why don't you give us a
 14 few minutes, if you would.
 15 - - -
 16 (Thereupon, a recess was had.)
 17 - - -
 18 Q. We're rounding third, if that helps at all.
 19 A. Good. Thankyou.
 20 Q. I want to lay some foundations here for some
 21 follow-up questions.
 22 Earlier you told us to determine what's an
 23 acceptable or unacceptable rate here at the Clinic
 24 you have to look at the frequency and the type of
 25 the procedure being performed?

58

- 1 A. I object to the use of the words acceptable and
 2 unacceptable.
 3 Q. What terms do you use?
 4 A. I don't know what an acceptable, unacceptable rate
 5 is. I think the issue is, is there a perceived
 6 problem, real problem. But unacceptable,
 7 acceptable, I don't know what that is.
 8 Q. So perceived problem, problem, what --
 9 A. Right.
 10 Q. Whether there's a problem depends on the type of
 11 procedure and the number of procedures, the
 12 frequency of the procedure?
 13 A. To determine incident rates of infection you need a
 14 numerator and denominator.
 15 Q. Would there ever be circumstances under which even
 16 one surgical site infection would be unacceptable or
 17 would be a problem?
 18 A. Yes.
 19 Q. Give me an example.
 20 A. Post-op Group A strep infection, in that particular
 21 sense you would look for a carrier in the OR or in
 22 anesthesia.
 23 Q. Anyothers?
 24 A. That is the classic one where only one case would be
 25 a sentinel event.

59

- 1 Q. What about involving an Enterobacteriaceae?
 2 A. That in and of itself, no.
 3 Q. One would not be enough to have it be a problem or
 4 perceived problem?
 5 A. Oh, yes, it could be.
 6 Q. Under what circumstances?
 7 A. If it was *Yersinia pestis*, which is an
 8 Enterobacteriaceae, if we had a case of plague I
 9 probably would get excited about that.
 10 MS. DISILVIO: What's the plague?
 11 THE WITNESS: *Yersinia pestis*.
 12 Q. Have you had any experience specifically involving
 13 *klebsiella oxytoca* outside of your experience here
 14 at The Cleveland Clinic?
 15 A. Experience in terms of treating those infections?
 16 Q. I'm sorry, in terms of any research or
 17 investigations from an epidemiological standpoint.
 18 A. I've done outbreak investigations where *klebsiella*
 19 was maybe a part of a collection of surgical site
 20 infections, but a specific *klebsiella oxytoca*, staph
 21 aureus, polymicrobial, no.
 22 Q. Earlier you said you did an investigation concerning
 23 an allegation whether there was a contaminated probe
 24 involved with Mary Lou Zimmerman?
 25 A. I'm sorry?

60

- 1 Q. Did you ever -- you talked earlier about how you
 2 reviewed this case to see whether or not a
 3 contaminated probe could have been the cause of the
 4 infection?
 5 A. No. If that's what you got out of it, you were
 6 mistaken. We reviewed the case to look at, again,
 7 postoperative *klebsiella*, wound infections of a
 8 neurosurgical site and staph aureus.
 9 Q. When was that investigation done?
 10 A. We do this all the time. Specifically we
 11 reviewed -- I reviewed it again this week but --
 12 Q. When was the initial review done?
 13 A. I review that data probably once a month. Official
 14 reports are quoted.
 15 Q. What specific data would you have reviewed?
 16 A. Wound infection rates, pathogens, we segregate out
 17 shunt infections specifically since those are pretty
 18 high risk, discuss with Mary, discuss any issues
 19 with the surgeons, so it's ongoing.
 20 Q. When was the first time you reviewed the medical
 21 chart of Mary Lou Zimmerman?
 22 A. Less than a week ago.
 23 Q. And how much time have you spent reviewing the case
 24 since the lawsuit has been filed?
 25 MS. DISILVIO: Objection. Totally

61

1 irrelevant, but you can answer.
 2 A. I probably spent reading through --
 3 MR. MALONE: Including time he spent
 4 with **us**? I mean, we've met with him before.
 5 I'm not sure the question is within the bounds
 6 of -- I'll let him answer it, but --
 7 A. Yeah, in terms of reviewing the deposition, which
 8 was, gosh, I would say an hour and a half of
 9 materials.
 10 Q. **So** the written materials, including the deposition
 11 and records, would be about an hour and a half?
 12 A. Right. Now, reviewing ongoing surgical site --
 13 Q. No, no, this particular case.
 14 A. Yes.
 15 Q. In addition **to** that, how much time have you spent
 16 with the lawyers from The Cleveland Clinic?
 17 MS. DISILVIO: Objection. Do not
 18 answer that question.
 19 MR. MALONE: Objection.
 20 MR. LINTON: How much time, that is not
 21 privileged.
 22 MR. MALONE: Any communication with **us**
 23 is beyond the bounds of --
 24 MR. LINTON: No, no, it's not a
 25 communication.

62

1 MR. MALONE: He's not going **to** answer
 2 it. It's not relevant. You're going to have
 3 to get a Judge before he answers how much time
 4 we spent with our employers and **our** employees'
 5 clients. We're not going to respond
 6 voluntarily.
 7 MR. RUF: Certainly the amount of time
 8 is relevant.
 9 MR. MALONE: No.
 10 MR. RUF: If he's going to render
 11 opinions in this case.
 12 MR. LINTON: It is.
 13 MR. MALONE: No, it's not.
 14 MR. LINTON: Absolutely.
 15 MS. DISILVIO: He answered how much
 16 time he spent reviewing the case. You're
 17 asking him time he spent meeting with his
 18 lawyers.
 19 MR. LINTON: Absolutely.
 20 MS. DISILVIO: And he's not going to
 21 answer that question --
 22 MR. LINTON: We'll file a brief.
 23 MS. DISILVIO: -- absent an order from
 24 the Court.
 25 MR. LINTON: On what basis?

63

1 MR. MALONE: **Attorney/client** privilege.
 2 MR. LINTON: How **is** that a
 3 communication? It's not work product, it's not
 4 privileged.
 5 MR. MALONE: **Go** ahead and file your
 6 brief.
 7 MR. LINTON: Tell me how it's a
 8 communication.
 9 MR. MALONE: Do you understand my
 10 position? He's not going to answer that. How
 11 much time he spends teaching me to try this
 12 lawsuit, how much time he spends teaching me is
 13 absolutely none **of** your concern.
 14 MR. LINTON: It's totally my concern.
 15 MR. MALONE: No, it's not. Let's move
 16 on. We're wasting time.
 17 MR. LINTON: I'm not going to move on.
 18 MR. MALONE: Then the deposition **is**
 19 over.
 20 MR. LINTON: You can end it if you want
 21 to end it.
 22 MR. MALONE: Do you have any other
 23 questions?
 24 MR. LINTON: I may have lots of
 25 questions, depending on what he says.

64

1 MR. MALONE: He's not going to answer
 2 it.
 3 MR. LINTON: **So** you're going to cut off
 4 the deposition?
 5 MR. MALONE: He's not going to answer
 6 that. **If you** don't have any other questions,
 7 we're done.
 8 MR. LINTON: I need to know what his
 9 answer is first.
 10 MR. MALONE: What's the difference if
 11 he spent a week with Jim Malone or ten
 12 minutes? That doesn't give you any insight.
 13 MR. LINTON: **It** gives me a lot, and
 14 we'll stop the deposition now, we'll get the
 15 Court order, and we'll resume.
 16 MR. MALONE: We're not coming back
 17 without the Court order.
 18 MR. LINTON: We'll bring him downtown.
 19 MR. MALONE: You're not bringing him
 20 downtown.
 21 MR. LINTON: I'm trying to -- sorry to
 22 inconvenience **you**.
 23 MR. MALONE: If you don't get this
 24 order, then the deposition is concluded,
 25 correct?

65

1 MR. LINTON: No.

2 MR. MALONE: You'd better ask him
3 follow-up questions.4 MR. LINTON I'm going to ask follow-up
5 questions after he answers the question.6 MS. DISILVIO Time he spent
7 communicating with us --

8 MR. MALONE: We're done.

9 MS. DISILVIO: -- is irrelevant if he's
10 teaching me stuff, Bob. That's not your
11 concern.12 MR. LINTON: I didn't ask that
13 question. It was simply time, time spent with
14 the lawyers of The Cleveland Clinic, period.15
16 STEVEN M. GORDON, M.D.
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1
2 CERTIFICATE3 The State of Ohio) SS:
4 County of Cuyahoga.)5
6 I, Laura L. Ware, a Notar Public within and
7 for the State of Ohio, do hereby certify that the
8 within named witness STEVEN M. GORDON, M.D., was by
9 me first duly sworn to testify the truth, the whole
10 truth, and nothing but the truth in the cause
11 aforesaid; that the testimony then given was reduced
12 by me to stenotypy in the presence of said witness,
13 subsequently transcribed into typewriting under my
14 direction, and that the foregoing is a true and
15 correct transcript of the testimony so given as
16 aforesaid.17 I do further certify that this deposition
18 was taken at the time and place as specified in the
19 foregoing caption, and that I am not a relative,
20 counsel or attorney of either party or otherwise
21 interested in the outcome of this action.22 IN WITNESS WHEREOF, I have hereunto set my
23 hand and affixed my seal of office at Cleveland,
24 Ohio, this 2nd day of November, 2000.25
26 
27 Laura L. Ware, Ware Reporting Service
28 21860 Crossbeam Lane, Rocky River, Ohio 44116
29 My commission expires May 17, 2003.

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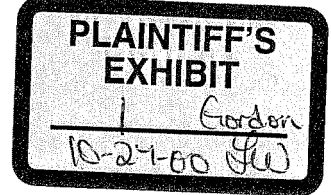
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Member, Infectious Disease Society of America
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Unit Commendation, Commissioned Corps, United States Public Health Service, Epidemiology Program Office (1990)

Physician's Recognition Award, American Medical Association (1990)

Unit Commendation, Commissioned Corps, United States Public Health Service, Hospital Infection Program (1989)

Alpha Omega Alpha, University of Chicago Pritzker School of Medicine (1987)

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Postgraduate Internal Medicine Review Course, The Cleveland Clinic Foundation (June, 1994, 1995, 1996, 1997)

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Publications

A. Articles

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B. Book Chapters

1. Gal AA, Gordon S. Viral, Mycoplasmic, Chlamydial and Rickettsial infections of the Lung. In: Pathology of Pulmonary Disease, editor, M Saldano, 1st edition, J.B. Lippincott 1994.
2. Gordon SM. New and Emerging Infectious Diseases. In: The Cleveland Clinic intensive Review of Internal Medicine. Editors, Stoller JK, Ahman M, and Longworth DL. 1st and 2nd editions, Williams & Wilkins, 2000.

C. Book Reviews

Respiratory Infections Diagnosis and Management, edited by James Pennington. Journal of Bronchology; April, 1995.

Fungal diseases of the lung. Sarosi GA and Davies SF, editors. 3rd edition. Lippincott Williams and Wilkins, Philadelphia, 2000.

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Education Journals

Editorial Staff, Cleveland Clinic Journal of Medicine
Scientific Reiviewer for Cleveland Clinic Journal of Medicine,
Clinical Infectious Diseases, American Journal of
Gastroenterology, Annals of Internal Medicine

Insititutional Responsibilities

Hospital Epidemiologist, Cleveland Clinic, 1995-
Chairman, Infection Control Committee, Cleveland Clinic, 1993-
Staff Benefits Committee, Cleveland Clinic, 1996-98
Medical Record Committee, Cleveland Clinic, 1994-97
Lung Transplant Selection Committee, Cleveland Clinic, 1995-

Clinical Practice, Research Interests, and Accomplishments

care of immunocompromised patients including HIV and transplant
study of hospital acquired infections

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June 26, 2000

Mark W. Ruf, Esq.
700 W. St. Clair Avenue
Cleveland, Ohio 44113

Mary Lou Zimmerman, et al vs. The Cleveland Clinic Foundation
Our File No. 2100-10-41986-00
Cuyahoga County Common Pleas Case No. 399411

Dear Mark:

Pursuant to the Court's recent order, please let the following serve to supplement Defendant's Answers to Interrogatories Nos. 10 and 39.

Interrogatory No. 10

As we discussed on June 26, 2000, the Cleveland Clinic Foundation does not keep statistics on surgical patients who have an isolated positive culture for Klebsiella Oxytoca. Rather, statistics are maintained for surgical patients who have a post-operative Klebsiella Oxytoca infection. Accordingly, the information you requested is set forth below for surgical patients with post-operative Klebsiella Oxytoca infections:

	<u>Date of Admission</u>	<u>Surgical Procedure</u>
1.	6/18/94	Colo-rectal
2.	8/25/94	Cardio-thoracic
3.	1/3/97	Cardio-thoracic
4.	10/28/97	Orthopedic
5.	1/20/98	Cardio-thoracic
6.	4/22/98	Neurosurgical
7.	4/27/98	Cardio-thoracic
8.	8/13/98	Cardio-thoracic
9.	9/22/98	Neurosurgical
10.	5/6/99	Neurosurgical

PLAINTIFF'S
EXHIBIT

D. Gordon
10-27-00 Lw

Mark W. Ruf, Esq.
Page 2 of 2
June 26, 2000

Interrogatory No. 39

In answering these Interrogatories, the following were used reviewed:

- 1.) Medical records of Mary Lou Zimmerman
- 2.) Electronic database of the Microbiology Department (proprietary to the CCF)
- 3.) Electronic database of the Infection Control Department (Proprietary to the CCF)
- 4.) Billing charges for equipment used during Mary Lou Zimmerman's operative procedure of 9/22/98
- 5.) Policies and procedures of the Cleveland Clinic Foundation
- 6.) Those documents identified and provided in Answers to Interrogatories

In addition, enclosed please find Defendant's Responses to Request for Production of Documents directed to the Cleveland Clinic Foundation.

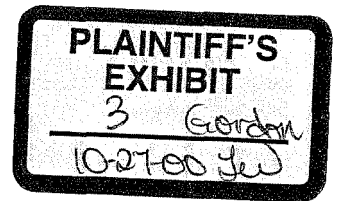
Should you have any questions regarding this information, please do not hesitate to call me or Jim Malone.

Very truly yours,

REMINER & REMINGER CO., L.P.A.


Marielena DiSilvio

MD/cms



IN THE COURT OF COMMON PLEAS
CUYAHOGA COUNTY, OHIO

MARY LOU ZIMMERMAN, et al,

Plaintiffs

-VS-

CLEVELAND CLINIC FOUNDATION,

Defendant

Case No. 399411

JUDGE JANET R. BURNSIDE

**RESPONSES TO REQUEST FOR
PRODUCTION OF DOCUMENTS
DIRECTED TO THE CLEVELAND
CLINIC FOUNDATION**

1. The logbook for bacteria cultures for the year 1998. (Redact all identification information for any individual patient for confidentiality purposes).

Response: In response to Request No. 1, please find Cumulative Test Statistics for 12/98, attached as Exhibit "A."

2. Any and all documentation or electronically stored information which would monitor or keep track of bacterial cultures for the year 1998.

Response: See response to No. 1, supra.

3. Any and all documentation which shows the organism susceptibility pattern for Klebsiella oxytoca for each inpatient that had a positive culture for Klebsiella oxytoca from 1993 through 1999. On each document, redact the patient's name for confidentiality purposes.

Response: Objection. Overboard and unduly burdensome. The Cleveland Clinic Foundation does not maintain statistics on isolated positive cultures for Klebsiella Oxytoca. Accordingly, this request would require the Cleveland Clinic Foundation to literally open and evaluate charts of each and every patient admitted to the hospital between 1993 and 1999 to locate this information, Furthermore, this Interrogatory calls for information that is objected to on the basis of the patient privilege.

Without waiving this objection, defendant directs plaintiffs to susceptibility statistics from 1995 through 1/28/2000, attached hereto as Exhibit "B."

4. Any and all hospital documents or electronically stored information from 1993 through 1999 which discusses *Klebsiella oxytoca* or patients with *Klebsiella oxytoca* infections.

Response: See response to request No. 3, supra.

5. Any and all documents or electronically stored information which is established a system for reporting, evaluating and maintaining records of infections and communicable disease among patients and employees and the collection of data which will be evaluated and utilized in control and prevention of nosocomial infections.

Response: In response to request No. 5 please be advised that there is a system for reporting evaluating and maintaining, records of infection. There is an electronic database in microbiology and an electronic database in infection control. These databases are proprietary to the Cleveland Clinic Foundation. The information sought is more properly the subject of deposition inquiry. This defendant will gladly produce the appropriate person (s) for deposition upon request.

6. The written minutes and pertinent records of all infection control committee meetings form 1993 through 1999.

Response: Objection. The information sought is immune from discovery by reason of Peer Review and Quality Management,

7. The infection control log for 1993 through 1999 with patient's names redacted.

Response: The Cleveland Clinic Foundation does not maintain a document entitled "Infection Control Log." Assuming the request seeks a "log" of all cultures, the request is objected to as overboard and unduly burdensome. It is believed that requested information would be in the thousands of pages and calls for information that is further objected to on the basis of the patient's privilege.

8. Any documentation or electronically stored information for the years 1993 through 1999 that showed a positive result for any type of surgical equipment for *Klebsiella oxytoca* from 1993 through 1999.

Response: No such document (s) exists.

9. Any and all documents or electronically stored information for any ordering or results of testing for pathogens for Mary Lou Zimmerman's post-operative brain infection.

Response: See medical records.

10. A certified copy of any and all medical records in the Defendant's possession for Mary Lou Zimmerman.

Response: A copy of Mary Lou Zimmerman's medical records are attached.

11. A copy of all medical billings for Mary Lou Zimmerman.

Response: Previously provided.

12. A copy of any and all publications The Cleveland Clinic follows for infection control and surveillance.

Response: The Cleveland Clinic Foundation does not per se "follow" any publications for infection control and surveillance. The Cleveland Clinic Foundation is strongly influenced by CDC guidelines, as well as several other good resources.

13. Copies of any and all radiology films for Mary Lou Zimmerman.

Response: Will supplement.

14. Copies of any and all documentation or electronically stored information in the possession of the Pathology Department at The Cleveland Clinic Foundation for Mary Lou Zimmerman.

Response: See medical records.

15. Copies of any and all publication Defendant finds is accurate and reliable on medical issues relevant to Mary Lou Zimmerman's care and treatment.

Response: This request is more properly the subject of inquiry during the deposition(s) of Mary Lou Zimmerman's caregiver(s).

16. Copies of any and all publications the Defendant will use to support medical opinions concerning Mary Lou Zimmerman's evaluation, care and treatment.

Response: Objection. Work product.

17. Copies of any and all documents obtained by subpoena.

Response: Will supplement if requested documents exist.

18. Copies of any and all documents obtained by medical release.

Response: See response to No. 17, supra.

19. Copies of any and all photographs of Mary Lou Zimmerman.

Response: See response to No. 17, supra.

20. Copies of any and all videotapes of Mary Lou Zimmerman or her surgery.

Response: See response to No. 17, supra.

21. Copies of any and all statements the Defendant has concerning Mary Lou Zimmerman.

Response: Other than statements contained in the medical record, no documents exist that are responsive to this request.

22. Copies of any and all documents or electronically stored information with Mary Lou Zimmerman's name on it.

Response: Other than the medical record, see documents attached as Exhibit "C".

23. A printout of all data or information stored electronically concerning Mary Lou Zimmerman.

Resuonse: See response to No. 22, supra.

24. A print-out of any and all tests or radiology films or x-rays that are stored electronically concerning Mary Lou Zimmerman.

Response: See medical record.

25. Copies of any and all documents or other evidence that will be used at trial or arbitration of this matter.

Resuonse: No decision has been made with respect to the identity of exhibits but it is expected that all medical records related to the Plaintiff's treatment will be offered.

26. Copies of any and all expert witness reports,

Response: Will supplement in accordance with the Court's Litigation schedule,

27. Copies of all documents in your expert witnesses files.

Response: Objection. Work product.

28. Produce all documents reviewed by you in responding to this discovery.

Response: All documentation has either previously been provided or are attached.

29. Produce all document which support any denial made by you, in whole or in part, to Plaintiff's Request for Admission.

Response: Will supplement if the requested documents exist.

Respectfully submitted:



James L. Malone (0019178)

Marilena DiSilvio (0064575)

REMINER & REMINGER CO., L.P.A.

The 113 St. Clair Building, N.E. - Suite 700
Cleveland, Ohio 44114

Phone: (216) 687-1311

Attorneys for Defendant

The Cleveland Clinic Foundation

AS TO OBJECTIONS:



James L. Malone

Marilena DiSilvio

CERTIFICATE OF SERVICE

A copy of the foregoing Answers to Requests for Production of Documents were mailed to plaintiffs' counsel by regular U.S. Mail, this 27th day of June, 2000, as follows:

Mark W. Ruf
Robert F. Linton, Jr.
700 W. St. Clair Avenue
Cleveland, Ohio 44113



JAMES L. MALONE
MARILENA DISILVIO

01/06/99
09:41

THE CLEVELAND CLINIC FOUNDATION
CUMULATIVE TEST STATISTICS FOR 12/98
Microbiology
Calendar Year to Date
HOSP. ID: CL1 ALL LOCATIONS

PAGE
116

TEST	INPATIENT		OUTPATIENT		OUTSIDE		TOTAL	
	MTD	YTD	MTD	YTD	MTD	YTD	MTD	YTD
AFBSUS AFB Susceptibil TFQ	0	0	0	2	7	102	7	164
TRV	0.00	0.00	0.00	140.00	490.00	11340.00	490.00	11480.00
AFC AFB Cult & Stai TFP	209	2580	134	1377	34	622	377	4579
TRV	13794.00	170280.00	8844.00	90882.00	2244.00	41052.00	24882.00	302214.00
AFCO AFB Culture Onl TFP	1	121	3	66	5	65	9	252
TRV	45.50	5505.50	136.50	3003.00	227.50	2957.50	409.50	11466.00
AFS AFB Stain Only TFQ	0	0	0	0	0	6	0	61
TRV	0.00	0.00	0.00	0.00	0.00	123.00	0.00	123.00
BCUL Acanthamoeba Cu TFP	1	1	0	9	0	0	1	10
TRV	45.50	45.50	0.00	409.50	0.00	0.00	45.50	455.00
AMCUL Anaerobe Cult/S TFQ	135	1551	62	797	2	14	199	2362
TRV	14512.50	166732.50	6665.00	85677.50	215.00	1505.00	21392.50	253915.00
AMIIS Anaerobe Tis Cu TFQ	67	862	31	332	2	9	100	1203
TRV	8676.50	111629.00	4014.50	42994.00	259.00	1165.50	12950.00	155788.50
ASSAY Assay Miscellan TFQ	0	5	0	0	0	5	0	10
TRV	0.00	180.00	0.00	0.00	0.00	180.00	0.00	360.00
BAD Bacteria Antige TFP	2	31	1	3	2	58	5	92
TRV	304.00	4712.00	752.00	456.00	304.00	8816.00	760.00	13984.00
BETACL Beta Strep Cult TFQ	0	0	12	230	0	1	12	231
TRV	0.00	0.00	252.00	4830.00	0.00	21.00	252.00	4851.00
BETADN Strep Gp A DNA TFQ	16	262	1451	14816	2	13	1469	15091
TRV	416.00	6812.00	37726.00	385216.00	52.00	338.00	38194.00	392366.00
BETASC Strep Gr A Scre TFQ	3	12	59	263	0	16	62	291
TRV	82.50	330.00	1622.50	7232.50	0.00	440.00	1705.00	8002.50
BLCUL Blood Culture TFQ	3504	41244	562	6689	95	989	4161	48922
TRV	112128.00	1319808.00	17984.00	214048.00	3040.00	31648.00	133152.00	1565504.00
BLSP Blood Cult Spec TFP	28	237	0	18	1	9	29	264
TRV	2128.00	18012.00	0.00	1368.00	76.00	684.00	2204.00	20064.00
CAD Crypto Antigen TFQ	25	312	21	157	11	162	57	631
TRV	637.50	7956.00	535.50	4003.50	280.50	4131.00	1453.50	16090.50
CDIFEI C. difficile EI TFP	305	3541	76	841	17	555	398	4937
TRV	16165.00	187673.00	4028.00	44573.00	901.00	29415.00	21094.00	261661.00

(pkg) = tests ordered as package components, revenue not tallied

01/06/99
09:41

THE CLEVELAND CLINIC FOUNDATION
CUMULATIVE TEST STATISTICS FOR 72/98
Microbiology
Calendar Year to Date
HOSP. ID: CL1 ALL LOCATIONS

PAGE
117

TEST	INPATIENT		OUTPATIENT		OUTSIDE		TOTAL	
	MTD	YTD	MTD	YTD	MTD	YTD	MTD	YTD
CGMST CSF Gram Stain TFQ	2	6	0	2	0	0	2	8
TRV	41.00	123.00	0.00	41.00	0.00	0.00	41.00	164.00
CLAAMP Chlamydia AmpL1 TFQ	0	16	15	342	6	174	21	532
TRV	0.00	245.00	0.00	6370.00	0.00	2156.00	0.00	8771.00
CLAONA Chlamydia DNA P TFP	0	2	0	19	0	147	0	168
TRV	0.00	90.00	0.00	855.00	0.00	6615.00	0.00	7560.00
CLAMY Chlamydia Cutt TFQ	3	33	70	629	16	526	89	1188
TRV	184.50	2029.50	4305.00	38683.50	984.00	32349.00	5473.50	73062.00
VBLD OM DNA DETECTI TFQ	76	923	87	1255	7	68	170	2246
TRV	0.00	15134.00	0.00	20930.00	0.00	885.50	0.00	36949.50
CONAFB Conc Procedure TFQ	145	2024	114	1135	0	2	259	3161
TRV	3190.00	44528.00	2508.00	24970.00	0.00	44.00	5698.00	69542.00
CRYSPO Cryptosporidia TFQ	0	15	0	9	2	18	2	42
TRV	0.00	630.00	0.00	378.00	84.00	756.00	84.00	1764.00
CSFCUL CSF Cult & Stai TFQ	136	2083	42	535	1	1	179	2619
TRV	11220.00	171847.50	3465.00	44137.50	82.50	82.50	14767.50	216067.50
DADNO Adenovirus DFA TFQ	0	7	14	120	0	2	14	129
TRV	0.00	353.50	707.00	6060.00	0.00	101.00	707.00	6514.50
DARK Darkfield Exam TFQ	0	0	0	0	0	1	0	1
TRV	0.00	0.00	0.00	0.00	0.00	42.00	0.00	42.00
RMFC Dermatophyte Cu TFQ	0	10	0	368	0	70	0	448
TRV	0.00	625.00	0.00	23000.00	0.00	4375.00	0.00	28000.00
DFLU Influenza DFA TFQ	0	9	0	4	0	6	0	19
TRV	0.00	454.50	0.00	202.00	0.00	303.00	0.00	959.50
DHSV Herpes Simplex TFQ	6	126	27	315	3	18	36	459
TRV	303.00	6363.00	1363.50	15907.50	151.50	909.00	1818.00	23179.50
DPARA Parainfluenza 1 TFQ	0	0	0	2	0	1	0	3
TRV	0.00	0.00	0.00	114.00	0.00	57.00	0.00	171.00
DRAP Resp. Antigen D TFQ	65	546	17	144	10	121	92	811
TRV	3282.50	27573.00	858.50	7272.00	505.00	6110.50	4646.00	40955.50
DRSV Resp. Syncitial TFQ	2	24	5	44	5	89	12	157
TRV	101.00	1212.00	252.50	2222.00	252.50	4494.50	606.00	7928.50

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		MTD	YTD	MTD	YTD	MTD	YTD	UTD	YTD
DVZV	Varicella Zoste TFP	2	54	7	119	0	6	9	179
	TRV	101.00	2727.00	353.50	6009.50	0.00	303.00	454.50	9039.50
EROTA	Rotavirus Ag De TFP	11	124	16	92	7	160	34	376
	TRV	533.50	6014.00	776.00	4462.00	339.50	7760.00	1649.00	18236.00
FCUL	Fungal Culture TFP	10	122	51	428	27	296	88	846
	TRV	455.00	5551.00	2320.50	19474.00	1228.50	13468.00	4004.00	38493.00
FCULSM	Fungal Cult & S TFP	166	2284	178	1553	29	303	373	4140
	TRV	10375.00	142750.00	11125.00	57062.50	1812.50	18937.50	23312.50	250750.00
FEAT	Fecal Fat/Qual TFP	1	24	1	41	11	131	13	196
	TRV	16.00	384.00	16.00	656.00	176.00	2096.00	208.00	3136.00
FIBERS	Meat Fibers/Sto TFP	0	1	0	0	0	3	0	4
	TRV	0.00	16.00	0.00	0.00	0.00	48.00	0.00	64.00
FLUCY	Assay Flucytosi TFP	0	7	0	0	0	3	0	10
	TRV	0.00	252.00	0.00	0.00	0.00	100.00	0.00	360.00
FLUNCSF	Fungus CSF Cult TFP	17	246	8	82	0	12	25	340
	TRV	1581.00	22878.00	744.00	7626.00	0.00	1116.00	2325.00	31620.00
FUNGSC	Fungus Screen TFP	14	201	62	900	64	863	140	1964
	TRV	420.00	6030.00	1860.00	27000.00	1920.00	25890.00	4200.00	58920.00
FUNGSM	Fungal Smear TFP	1	28	5	73	3	21	9	122
	TRV	17.00	476.00	85.00	1241.00	51.00	357.00	153.00	2074.00
INSUS	Fungal Suscept. TFP	0	2	0	0	0	43	0	45
	TRV	0.00	41.00	0.00	0.00	0.00	881.50	0.00	922.50
GCAMP	GC Amplificatio TFP	0	21	11	293	5	150	16	464
	TRV	0.00	148.00	0.00	4292.00	0.00	1110.00	0.00	5550.00
GCCAMP	GC/Chlamydia Am TFP	22	341	623	7252	63	762	708	8355
	TRV	0.00	5332.00	0.00	127968.00	0.00	11782.00	0.00	145082.00
GCCONA	GC/Chlamydia DN TFP	0	5	0	15	0	91	0	111
	TRV	0.00	160.00	0.00	240.00	0.00	2880.00	0.00	3280.00
GCDNA	GC DNA Probe TFP	0	1	0	14	0	122	0	137
	TRV	0.00	28.00	0.00	392.00	0.00	3416.00	0.00	3836.00
HANDL	Handling Fee TFP	0	0	0	0	0	5	0	5
	TRV	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00

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		MTD	YTD	MTD	YTD	XTD	YTD	MTD	YTD
HISTCL Fungal Blood Cu	TFP	5	152	1	19	14	228	20	399
	TRV	337.50	10260.00	67.50	1282.50	945.00	15390.00	1350.00	26932.50
HPV HPV DNA Assay	TFQ	0	3	121	1207	10	137	131	1347
	TRV	0.00	99.00	0.00	23265.00	0.00	2673.00	0.00	26037.00
HSV1YP Herpes Virus Ty	TFP	0	0	0	4	0	2	0	6
	TRV	0.00	0.00	0.00	134.00	0.00	67.00	0.00	201.00
IDAER2 ID Aerobe #2	TFQ	111	1573	69	918	16	91	196	2582
	TRV	2275.50	32246.50	1414.50	18819.00	328.00	1865.50	4018.00	52931.00
IDAER3 ID Aerobe #3	TFQ	27	412	14	229	6	28	47	669
	TRV	553.50	8446.00	287.00	4694.50	123.00	574.00	963.50	13714.50
IDAER4 ID Aerobe #4	TFQ	0	39	0	18	0	0	0	57
	TRV	0.00	799.50	0.00	369.00	0.00	0.00	0.00	1168.50
IDAER5 ID Aerobe #5	TFQ	0	2	0	2	0	0	0	4
	TRV	0.00	41.00	0.00	41.00	0.00	0.00	0.00	82.00
IDAERO ID Aerobe	TFQ	687	8340	301	3581	64	339	1052	12260
	TRV	14083.50	170970.00	6170.50	73410.50	1312.00	6949.50	21566.00	251330.00
IDAFEB ID AFB Biochemi	TFQ	0	3	0	4	0	1	0	8
	TRV	0.00	177.00	0.00	236.00	0.00	59.00	0.00	472.00
IDAFBD ID AFB by Probe	TFQ	0	28	0	26	0	5	0	59
	TRV	0.00	2660.00	0.00	2470.00	0.00	475.00	0.00	5605.00
IDANA2 ID Anaerobe #2	TFQ	2	35	0	11	0	1	2	47
	TRV	64.00	1120.00	0.00	352.00	0.00	32.00	64.00	1504.00
IDANA3 ID Anaerobe #3	TFQ	0	5	0	0	0	0	0	5
	TRV	0.00	160.00	0.00	0.00	0.00	0.00	0.00	160.00
IDANAE ID Anaerobe	TFQ	21	313	7	144	0	6	28	463
	TRV	672.00	10016.00	224.00	4608.00	0.00	192.00	896.00	14816.00
IDDNA1 ID DNA Probe #1	TFP	0	35	2	29	2	6	4	70
	TRV	0.00	1662.50	95.00	1377.50	95.00	285.00	190.00	3325.00
IDDNA2 ID DNA Probe #2	TFQ	0	5	0	6	0	0	0	11
	TRV	0.00	237.50	0.00	285.00	0.00	0.00	0.00	522.50
IDFUN2 ID Fungus #2	TFQ	0	9	1	12	0	3	1	24
	TRV	0.00	198.00	22.00	264.00	0.00	66.00	22.00	525.00

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		MTD	YTD	MTD	YTD	MTD	YTD	MTD	YTD	
IDFUNG ID Fungus	TFQ	35	445	40	458	0	46	75	949	✓
	TRV	770.00	9790.00	880.00	10076.00	0.00	1012.00	1650.00	20878.00	
IDURI2 ID Urine #2	TFQ	16	258	29	353	5	26	50	637	✓
	TRV	328.00	5289.00	594.50	7236.50	102.50	533.00	1025.00	13058.50	
IDURI3 ID Urine #3	TFQ	0	1	1	4	0	0	1	5	✓
	TRV	0.00	20.50	20.50	82.00	0.00	0.00	20.50	102.50	
IDURI4 ID Urine #4	TFQ	0	0	1	1	0	0	1	1	✓
	TRV	0.00	0.00	20.50	20.50	0.00	0.00	20.50	20.50	
IDURIN ID Urine	TFQ	130	2047	340	4703	49	161	519	6911	✓
	TRV	2665.00	41963.50	6970.00	96411.50	1004.50	3300.50	10639.50	141675.50	
LEGCUL Legionella Cult	TFQ	0	0	0	0	10	133	10	133	✓
	TRV	0.00	0.00	0.00	0.00	760.00	10108.00	760.00	10108.00	
LEGFA Legionella DFA	TFQ	2	36	3	9	11	149	16	194	
	TRV	114.00	2052.00	171.00	513.00	627.00	8493.00	912.00	11058.00	
LEGION Legionella Cult	TFQ	21	231	21	180	0	0	42	411	✓
	TRV	2793.00	30723.00	2793.00	23940.00	0.00	0.00	5586.00	54663.00	
LEPTO Leptospira Cult	TFQ	1	6	0	0	0	3	1	9	✓
	TRV	61.50	369.00	0.00	0.00	0.00	184.50	61.50	553.50	
MALARI Blood Parasites	TFQ	5	14	2	19	2	14	9	47	✓
	TRV	210.00	588.00	84.00	798.00	84.00	588.00	378.00	1974.00	
MGMST Misc Gram Stain	TFQ	1	45	42	367	5	64	48	476	✓
	TRV	20.50	922.50	861.00	7523.50	102.50	1312.00	984.00	9758.00	
MICSP0 Microsporidia E	TFQ	0	17	0	15	0	17	0	49	✓
	TRV	0.00	255.00	0.00	225.00	0.00	255.00	0.00	735.00	
MISCCS Misc Cult & Sta	TFQ	331	3876	230	2980	23	372	584	7228	✓
	TRV	19363.50	226746.00	13455.00	174330.00	1345.50	21762.00	34164.00	422838.00	
MISCGC Misc GC Screen	TFQ	1	5	4	51	6	14	11	70	✓
	TRV	27.50	137.50	110.00	1402.50	165.00	385.00	302.50	1925.00	
MISCSC Misc Cult Scree	TFQ	23	410	19	276	99	1218	141	1904	✓
	TRV	632.50	11275.00	522.50	7590.00	2722.50	33495.00	3877.50	52360.00	
MISCSP Misc Cult Speci	TFQ	0	6	0	0	0	3	0	9	✓
	TRV	0.00	456.00	0.00	0.00	0.00	228.00	0.00	684.00	

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		MTD	YTD	MTD	YTD	MTD	YTD	MTD	YTD
MISCUL Misc. Culture	TFQ	161	2173	78	848	42	106	281	3127
	TRV	6118.00	82574.00	2964.00	32224.00	1596.00	4028.00	10678.00	118826.00
MTBAMP MTB Amplificati	TFQ	0	5	0	2	0	23	0	35
	TRV	0.00	0.00	0.00	0.00	0.00	594.00	0.00	594.00
MYPLAS Mycoplasma Cult	TFQ	2	28	66	691	13	151	81	870
	TRV	106.00	1484.00	3498.00	36623.00	689.00	8003.00	4293.00	46110.00
NOCARC Nocardia Cult	TFQ	0	1	0	0	0	3	0	4
	TRV	0.00	45.50	0.00	0.00	0.00	136.50	0.00	182.00
CARD Nocardia Cult/s	TFQ	26	265	24	206	0	16	50	487
	TRV	1625.00	16562.50	1500.00	12875.00	0.00	1000.00	3125.00	30437.50
OB Occult blood Ex	TFP	2	42	243	2412	4	13	249	2467
	TRV	32.00	672.00	3888.00	38592.00	64.00	208.00	3984.00	39472.00
OIOAER Org IO Aerobe	TFQ	0	7	0	1	11	188	11	196
	TRV	0.00	143.50	0.00	20.50	225.50	3854.00	225.50	4018.00
OIOAFB Org ID AFB	TFQ	0	0	0	0	7	255	7	255
	TRV	0.00	0.05	0.00	0.00	413.00	15045.00	413.00	15045.00
OIOANA Org IO Anaerobe	TFQ	0	0	0	1	0	6	0	7
	TRV	0.00	0.00	0.00	32.00	0.00	192.00	0.00	224.00
OIOFUN Org IO Fungus	TFQ	0	1	0	0	3	71	3	72
	TRV	0.00	22.00	0.00	0.00	66.00	1562.00	66.00	1584.00
Organism MIC	TFQ	1	4	0	1	15	214	16	219
	TRV	36.00	144.00	0.00	36.00	540.00	7704.00	576.00	7884.00
OVAP Ova & Parasite	TFQ	3	28	3	57	80	1164	86	1249
	TRV	171.00	1596.05	171.00	3249.00	4560.00	66348.00	4902.00	71193.00
OVAPSC Ova & Parasite	TFQ	46	614	100	1340	2	16	148	1970
	TRV	0.00	5680.00	0.00	10080.00	0.00	160.00	0.00	15920.00
PCP Pneumocystis Ex	TFQ	24	241	24	183	4	24	52	448
	TRV	972.00	9760.50	972.00	7411.50	162.00	972.00	2106.00	18144.00
PCPOFA Pneumocystis Ex	TFQ	0	0	0	0	0	1	0	1
	TRV	0.00	0.00	0.00	0.00	0.00	58.00	0.00	58.00
PHENOL Phenolphthalein	TFP	0	14	1	7	4	37	5	58
	TRV	0.00	224.05	16.00	112.00	64.00	592.00	80.00	928.00

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TEST II		INPATIENT		OUTPATIENT		OUTSIDE		TOTAL	
		MTD	YTD	MTD	YTD	MTD	YTD	MTD	YTD
QCUL	Tissue Cult Qua TFQ	0	2	0	0	0	4	0	6
	TRV	0.00	241.00	0.00	0.00	0.00	482.00	0.00	723.00
RCULST	Respiratory Cul TFQ	348	4082	49	460	18	35	415	4577
	TRV	20358.00	238797.00	2866.50	26910.00	1053.00	2047.50	24277.50	267754.50
RESCUL	Respiratory Cul TFQ	5	95	4	96	12	32	21	223
	TRV	190.00	3610.00	152.00	3648.00	456.00	1216.00	798.00	8474.00
RESPGC	Resp GC Screen TFQ	0	2	0	15	1	1	1	18
	TRV	0.00	55.00	0.00	412.50	27.50	27.50	27.50	495.00
SPSC	Resp Cult Scree TFQ	0	3	0	2	0	1	0	6
	TRV	0.00	82.50	0.00	55.00	0.00	27.50	0.00	165.00
RESPSP	Resp Cult/Speci TFQ	0	9	3	18	2	13	5	40
	TRV	0.00	684.00	228.00	1368.00	152.00	988.00	380.00	3040.00
RGMST	Respiratory Gra TFP	21	221	21	180	0	0	42	401
	TRV	430.50	4530.50	430.50	3690.00	0.00	0.00	861.00	8220.50
SRT	Serum Bact Tite TFQ	0	2	0	0	0	10	0	12
	TRV	0.00	72.00	0.00	0.00	0.00	360.00	0.00	432.00
SCORE	Scored Specimen TFP	105	1330	8	114	0	1	113	1445
	TRV	2152.50	27265.00	164.00	2337.00	0.00	20.50	2316.50	29622.50
SPH	Fecal pH TFQ	0	6	2	4	2	4	4	14
	TRV	0.00	96.00	32.00	64.00	32.00	64.00	64.00	224.00
OCUL	Stool Cult TFQ	56	772	106	1152	7	85	169	2009
	TRV	3136.00	43232.00	5936.00	64512.00	392.00	4760.00	9464.00	112504.00
STOSP	Stool Cult, Spe TFQ	4	91	9	120	5	107	18	318
	TRV	304.00	6916.00	684.00	9120.00	380.00	8132.00	1368.00	24168.00
STRAIN	Molecular Strai TFP	0	0	0	0	0	9	0	9
	TRV	0.00	0.00	0.00	0.00	0.00	765.00	0.00	765.00
SYNRGY	Antibiotics in TFQ	0	0	0	0	0	2	0	2
	TRV	0.00	0.00	0.00	0.00	0.00	204.00	0.00	204.00
TAPE	Pinworm Prep TFQ	0	0	3	31	0	0	3	31
	TRV	0.00	0.00	61.50	635.50	0.00	0.00	61.50	635.50
THRCUL	Throat Cu lt/Rou TFP	0	0	1	11	2	2	3	38
	TRV	0.00	0.00	38.00	415.00	76.00	1026.00	114.00	1444.00

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		MTD	YTD	MTD	YTD	MTD	YTD	MTD	YTD
TISCUL Tissue Cult & s	TFQ	28	383	23	166	0	7	51	556
	TRV	2254.00	30831.50	1851.50	13363.00	0.00	563.50	4105.50	44758.00
TRICHO Trichomonas Pre	TFQ	0	7	9	105	0	0	9	112
	TRV	0.00	143.50	184.50	2152.50	0.00	0.00	184.50	2296.00
UGMST Urine Gram Stai	TFQ	8	130	4	46	0	1	12	177
	TRV	164.00	2665.00	82.00	943.00	0.00	20.50	246.00	3628.50
URCUL Urine Culture	TFQ	408	6241	695	9694	124	442	1227	16377
	TRV	13668.00	209073.50	23282.50	324749.00	4154.00	14807.00	41104.50	548629.50
UREASC Urease Test/H p	TFQ	10	128	28	405	1	2	39	535
	TRV	230.00	2944.00	644.00	9315.00	23.00	46.00	897.00	12305.00
URGC Urine GC Screen	TFQ	0	0	1	4	0	1	1	5
	TRV	0.00	0.00	27.50	110.00	0.00	27.50	27.50	137.50
RSC Urine screen/Bi	TFQ	1360	16793	1671	19789	6	12	3037	36594
	TRV	23120.00	285481.00	28407.00	336413.00	102.00	204.00	51629.00	622098.00
URSP Urine cult/Spec	TFQ	5	37	44	346	0	0	49	383
	TRV	380.00	2812.00	3344.00	26296.00	0.00	0.00	3724.00	29108.00
VAONO Adenovirus Cult	TFQ	22	243	33	293	2	33	57	569
	TRV	2376.00	26244.00	3564.00	31644.00	216.00	3564.00	6156.00	61452.00
VCMV Cytomegalovirus	TFQ	25	387	24	276	8	119	57	782
	TRV	2700.00	41796.00	2592.00	29808.00	864.00	12852.00	6156.00	84456.00
VENT Enterovirus Cul	TFQ	5	104	0	20	3	86	8	210
	TRV	372.50	7748.00	0.00	1490.00	223.50	6407.00	596.00	15645.00
VFLU Influenza cultu	TFQ	22	133	20	81	5	95	47	309
	TRV	2376.00	14364.00	2160.00	8748.00	540.00	10260.00	5076.00	33372.00
VHSV Herpes Simplex	TFQ	29	400	75	872	59	831	163	2103
	TRV	2610.00	36000.00	6750.00	78480.00	5310.00	74790.00	14670.00	189270.00
VMEAS Measles Virus C	TFQ	0	1	0	0	1	3	1	4
	TRV	0.00	108.00	0.00	0.00	108.00	324.00	108.00	432.00
VMUMP Mumps Virus Cul	TFQ	0	2	0	0	1	2	1	4
	TRV	0.00	216.00	0.00	0.00	108.00	216.00	108.00	432.00
VPARA Parainfluenza 1	TFQ	22	117	20	75	0	21	42	213
	TRV	2376.00	12636.00	2160.00	8100.00	0.00	2268.00	4536.00	23004.00

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THE CLEVELAND CLINIC FOUNDATION
CUMULATIVE TEST STATISTICS FOR 12/95
Microbiology
Calendar Year to Date
HOSP. ID: CL? ALL LOCATIONS

PAGE
124

TEST 	INPATIENT		OUTPATIENT		OUTSIDE		TOTAL		
	MTD	YTD	MTD	YTD	MTD	YTD	MTD	YTD	
VPIMMR Viral Cult. Res	TFQ	0	0	0	0	6	40	6	40
	TRV	0.00	0.00	0.00	0.00	1350.00	9000.00	1350.00	9000.00
VPMISC Viral Cult. Mis	TFQ	0	0	0	1	13	103	13	104
	TRV	0.00	0.00	0.00	150.00	1950.00	15450.00	1950.00	15600.00
VPRESP Viral Cult. Res	TFQ	0	0	0	0	7	54	7	54
	TRV	0.00	0.00	0.00	0.00	875.00	6750.00	875.00	6750.00
VRSV Resp. Syncitial	TFQ	22	121	20	97	1	24	43	242
	TRV	2376.00	13068.00	2160.00	10476.00	108.00	2592.00	4644.00	26136.00
VVZV Varicella Zoste	TFQ	3	169	6	239	3	50	12	458
	TRV	324.00	18252.00	648.00	25812.00	324.00	5400.00	1296.00	49464.00
ZZ00 Susceptibility	TFQ	565	7158	566	7143	117	835	1248	15136
	TRV	14832.00	187941.00	14751.50	186839.50	3077.50	30293.50	32661.00	405074.00
ZZ01 Susceptibility	TFQ	103	1418	62	867	18	96	183	2381
	TRV	2698.00	37111.00	1612.00	22552.00	468.00	2638.00	4778.00	62301.00
ZZ02 Susceptibility	TFQ	21	273	9	135	6	23	36	431
	TRV	546.00	7163.50	234.00	3510.00	156.00	598.00	936.00	11271.50
ZZ03 Susceptibility	TFQ	1	35	1	15	0	1	2	51
	TRV	26.00	910.00	26.00	390.00	0.00	26.00	52.00	1326.00
ZZ04 Susceptibility	TFQ	0	4	0	1	0	0	0	5
	TRV	0.00	104.00	0.00	26.00	0.00	0.00	0.00	130.00
ZZ05 Susceptibility	TFQ	0	3	0	0	0	0	0	3
	TRV	0.00	113.50	0.00	0.00	0.00	0.00	0.00	113.50
ZZ06 Susceptibility	TFQ	0	2	0	0	0	0	0	2
	TRV	0.00	52.00	0.00	0.00	0.00	0.00	0.00	52.00
ZZ07 Susceptibility	TFQ	0	1	0	0	0	0	0	1
	TRV	0.00	26.00	0.00	0.00	0.00	0.00	0.00	26.00
Microbiolog TOTAL	TFQ	9857	122723	9069	105633	1374	15468	20300	243824
	TRV	354786.50	4415643.00	265544.00	3209947.00	56297.50	723206.50	676628.00	8348796.50

(pkg) = tests ordered as package components, revenue not tallied

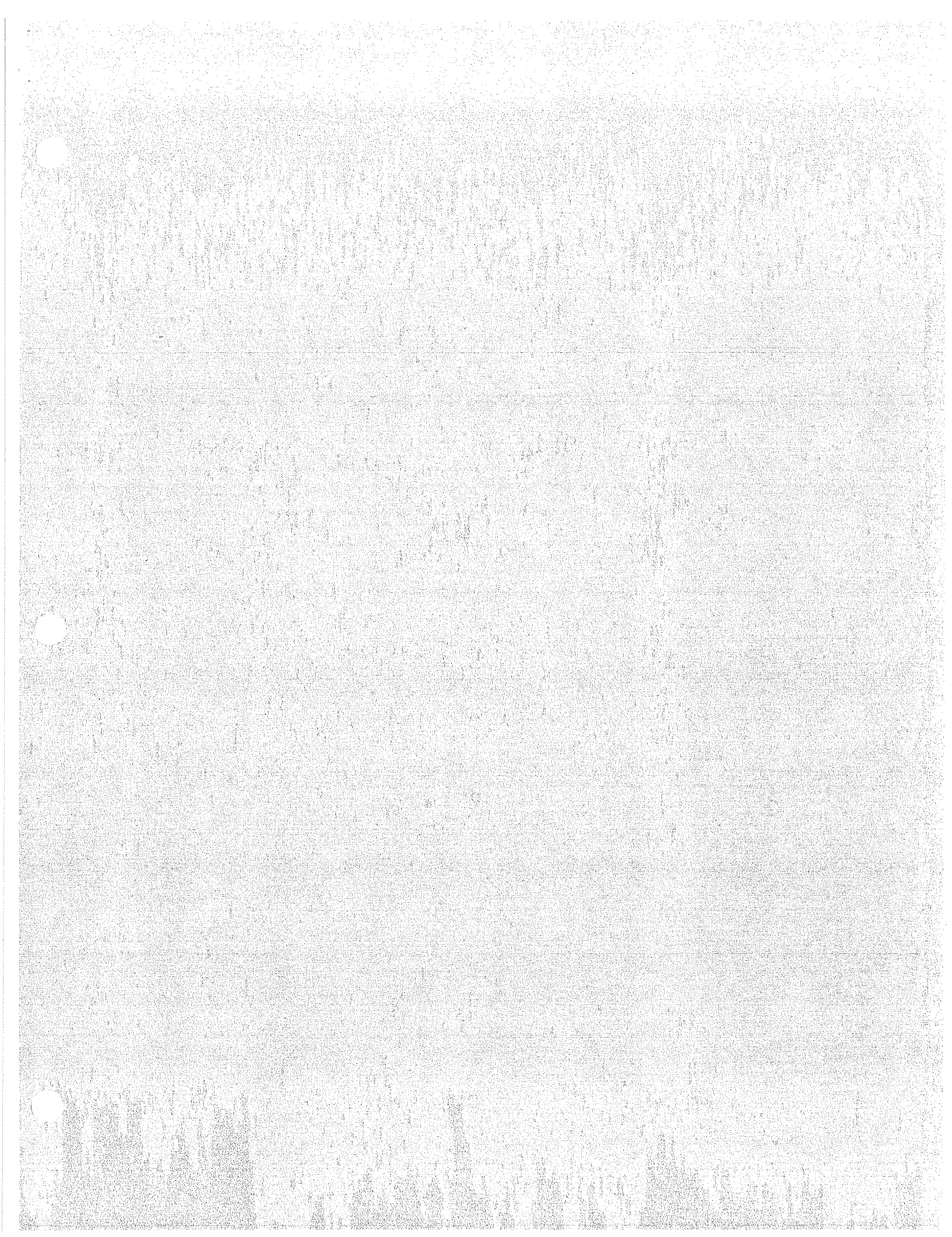


Table 1. PERCENTAGE OF GRAM-NEGATIVE BACILLI SUSCEPTIBLE TO VARIOUS ANTIMICROBIAL AGENTS AT THE CLEVELAND CLINIC

	Antimicrobial (breakpoint MIC, µg/ml)								
	Ampicillin (≤ 8)	Amoxicillin/ Clavulanate (≤ 8)	Cefazolin (≤ 8)	Ceftizoxime (≤ 8)	Ceftazidime (≤ 8)	Aztreonam (≤ 8)	Ticarcillin/ Clavulanate (≤ 16)	Piperacillin (≤ 16)	Imipenem (≤ 4)
<i>Acinetobacter anitratus</i>	4	27	0	26	20		94	82	100
<i>Alcaligenes xylosoxidans</i>	29	79	0	0	82		96	96	82
<i>Citrobacter diversus</i>	0	84	94	100	100		94	100	100
<i>Citrobacter freundii</i>	3	6	6	68	41		63	58	100
<i>Enterobacter aerogenes</i>	0	3	5	75	67		58	79	99
<i>Enterobacter cloacae</i>	1	2	1	73	54		68	75	100
<i>Escherichia coli</i>	66	77	95	100	97		84	68	100
<i>Klebsiella oxytoca</i>	0	88	58	100	92		87	93	100
<i>Klebsiella pneumoniae</i>	0	89	96	100	100		89	89	100
<i>Morganella morganii</i>	3	1	4	84	83		94	92	100
<i>Proteus mirabilis</i>	90	84	97	100	100		100	96	89
<i>Proteus vulgaris</i>	0	6	0	100	100		100	86	100
<i>Pseudomonas aeruginosa</i>	--	--	--	--	92	84	90 ^d	95	73
<i>Serratia marcescens</i>	2	2	0	99	100		89	100	100
<i>Xanthomonas maltophilia</i>	3	3	1	3	49		73	7	1

Table 1. PERCENTAGE OF GRAM-NEGATIVE BACILLI SUSCEPTIBLE TO VARIOUS ANTIMICROBIAL AGENTS AT THE CLEVELAND CLINIC.

	Antimicrobial (breakpoint MIC, µg/ml)			
	Gentamicin (≤ 4)	TMP/SMX (≤ 2/40)	Ciprofloxacin (≤ 2)	Nitrofurantoin ^a (≤ 32)
<i>Acinetobacter anitratus</i>	25	39	25	0
<i>Alcaligenes xylosoxidans</i>	0	92	17	0
<i>Citrobacter diversus</i>	94	94	92	
<i>Citrobacter freundii</i>	87	75	88	96
<i>Enterobacter aerogenes</i>	95	94	89	38
<i>Enterobacter cloacae</i>	98	97	96	
<i>Escherichia coli</i>	99	88	99	98
<i>Klebsiella oxytoca</i>	91	94	97	86
<i>Klebsiella pneumoniae</i>	99	86	99	47
<i>Morganella morganii</i>	100	93	98	14
<i>Proteus mirabilis</i>	95	93	100	4
<i>Proteus vulgaris</i>	100	94	100	18
<i>Pseudomonas aeruginosa</i>	83 ^b	--	84	--
<i>Serratia marcescens</i>	98	95	92	0
<i>Xanthomonas maltophilia</i>	6	97	42	0

^a Results are from initial isolates of species represented by at least 10 isolates tested between 2/1/95 and 10/14/95 by Vitek System from all sources, except when otherwise noted. Breakpoints for susceptibility are those defined by NCCLS.

^b 62% of gentamicin-resistant isolates of *P. aeruginosa* were susceptible to tobramycin.

^c Tested against urinary isolates only.

^d Values indicate percent susceptible to ticarcillin alone.

Table 2. PERCENTAGE OF GRAM-POSITIVE COCCI SUSCEPTIBLE TO VARIOUS ANTIMICROBIAL AGENTS AT THE CLEVELAND CLINIC^a

	Antimicrobial (breakpoint MIC $\mu\text{g/ml}$)							
	Penicillin (≤ 0.12)	Oxacillin ^b (≤ 2)	Ampicillin (≤ 8)	Clindamycin (≤ 0.5)	Ceftriaxone (≤ 0.5)	Vancomycin (≤ 4)	Tetracycline (≤ 4)	TMP/SMX ($\leq 2/40$)
<i>Staphylococcus aureus</i>	8	70	--	65	--	100	92	76
<i>Staphylococcus coagulase-negative</i>	17	48	--	34	--	100	77	46
<i>Enterococcus</i> ^c	--	--	94	--	--	95	--	--
<i>Streptococcus pneumoniae</i>	79 ^d	--	--	--	93 ^e	100	--	--

^a Results are for isolates tested between 2/1/95 and 10/14/95. Breakpoints for susceptibility are those defined by NCCLS.

^b Oxacillin-susceptible staphylococci are also susceptible to cefazolin, amoxicillin/clavulanate and ticarcillin/clavulanate.

^c High level aminoglycoside resistance for 109 enterococcal isolates from blood was 57% for gentamicin and 58% for streptomycin.

^d An additional 13% of pneumococcal isolates had penicillin MICs of 0.1-1.0 $\mu\text{g/ml}$ (intermediate category).

^e An additional 4% of pneumococcal isolates had ceftriaxone MICs of 1 $\mu\text{g/ml}$ (intermediate category).

Antimicrobial Susceptibilities of Major ICU Isolates^a

	G20	G50	G51	G52	G53	G54	G60	G61	G62
<u>Inducible Enterics^b</u>									
Ceftizoxime	75	81	72	88	78	76	85	77	41
Ceftazidime	89	80	54	80	76	63	75	69	41
Piperacillin	92	84	68	87	75	76	100	67	62
Ticarcillin/Clav	75	81	58	76	74	57	77	54	29
Imipenem	100	100	100	100	100	100	100	100	100
Ciprofloxacin	92	100	100	100	86	100	100	89	74
<u>P. aeruginosa</u>									
Ceftazidime	73	90	90	100	83	94	84	97	66
Piperacillin	85	100	100	100	82	100	90	100	94
Ticarcillin	67	100	95	100	90	100	84	85	83
Imipenem	91	62	82	77	91	77	89	46	85
Ciprofloxacin	73	90	90	100	83	100	89	86	80
<u>S. aureus</u>									
Oxacillin	55	18	43	44	82	67	75	48	40

^a Based on results collected between 2/1/95 and 10/14/95, excluding "repeats" (same isolate from same source from same patient on same day).

^b Inducible enterics represent Citrobacter freundii, Enterobacter spp., Providencia stuartii, and Serratia marcescens which produce chromosomal group I β -lactamase and which share similar susceptibility patterns for β -lactams. They are grouped together since numbers per species were often insufficient for statistical analysis.

THE CLEVELAND CLINIC FOUNDATION
 ANTIMICROBIC SUSCEPTIBILITY REPORT FOR 10/1995 - 01/2000
 For Specified Ordering Locations
 All Methods

Gram negative bacilli

ORGANISM NAME	TOTAL SUSC	AK	AKIK	AKSUL	AKXCL	AZT	CFPM	CFZL
Klebsiella oxytoca	314	313 99%	312 100%	114 31%	199 61%	234 88%	126 98%	313 52%
		CIPRO	CTAX	CTRIAX	FD	GM	IMIP	PIP
		313 91%	5 100%	113 96%	312 96%	313 93%	313 100%	312 81%
		PIPTAZ	STUDYL	STUDYK	SXT	TAZ	TE	TICCL
		124 82%	9 67%	9 100%	313 94%	313 90%	270 87%	199 81%
		TIZ	TO					
		203 86%	311 94%					

Minimal Inhibitory Concentration Report

from 10/15/1995 to 01/28/2000

Request Parameters

HOSP ID : CL1

Date : 10/15/1995 to 01/28/2000

Include Dups : N

Location : CICS,E14,E20,G100,G101,G110,G111,G20,G50,G50S,G51,G52,G53,G54,G60,G61,G62,G70,G71,G80,G81,G90,
G91,H20,H21,H22,H23,H50,H51,H60,H61,H62,H70,H71,H80,H81,HOLD,LIN8,M30,M31,M32,M33,M35,M41,M43,
M50,M50S,M51,M52,M53,M60,M61,M62,M63,M64,M70,M71,M72,M73,M80,MEX,OR,ORE2,ORE3,ORH2,ORH3,ORH4,P047,
P47,P47D,P58,P77,P78,PAR,PRE,SCHT,SURG,UNIN,UNK

Organism : KLEUX

Drug : All

Separate Locations : N

from 10/15/1995 to 01/28/2000

for Locations Selected

HOSP ID : CL1

Drug	Source	Count	<.06	.06	<.5	.5	<1	1	2	<4	4	<8	8	>8	<10	10	MORE MICs-->
Ampicillin	ABSCCESS/WOUNDS	102															
	BLOODS	66															
	BODY FLUIDS	46															
	CSF	1															
	GENITAL	2															
	MISCELLANEOUS	21															
	RESPIRATORY	85															
	STOOL/URINES	181															
	TISSUE	20															
	TOTAL	524															
Amikacin	ABSCCESS/WOUNDS	68							97			99		100			
	BLOODS	51							96	98	100						
	BODY FLUIDS	21							95		100						
	CSF	1							100								
	GENITAL	1							100								
	MISCELLANEOUS	16							100								
	RESPIRATORY	49							98		100						
	STOOL/URINES	123							97		98			100			
	TISSUE	14							93		100						
	TOTAL	344							97	97	99			100			
Ampicillin-Sulb	ABSCCESS/WOUNDS	21												29			
	BLOODS	14										7		43			
	BODY FLUIDS	7												43			
	MISCELLANEOUS	8										13		25			
	RESPIRATORY	15										20		33			
	STOOL/URINES	48										13		27			
	TISSUE	3												33			
	TOTAL	116										9		31			
Amoxicillin-Cla	ABSCCESS/WOUNDS	81												81			
	BLOODS	52												73			
	BODY FLUIDS	39												72			
	CSF	1												100			
	GENITAL	2												100			
	MISCELLANEOUS	13												85			
	RESPIRATORY	70											1	79			
	STOOL/URINES	134											1	78			
	TISSUE	17							6					82			
	TOTAL	409											1	78			
Aztreonam	ABSCCESS/WOUNDS	54												87			
	BLOODS	36												81			
	BODY FLUIDS	16												75			
	CSF	1												100			
	GENITAL	1												100			
	MISCELLANEOUS	11												100			
	RESPIRATORY	41											2	93			
	STOOL/URINES	91												90			
	TISSUE	12							8					100			
	TOTAL	263											1	89			

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Minimal Inhibitory Concentration Report for *Klebsiella oxytoca*

2

from 10/15/1995 to 01/28/2000

for Locations Selected

HOSP ID : CL1

Drug	Source	Count	<.06	.06	<.5	.5	<1	1	2	<4	4	<8	8	>8	<10	10	MORE	MICS-->
tetan	RESPIRATORY	1																
	STOOL/URINES	4																
	TOTAL	5																
Cefuroxime	STOOL/URINES	4										100						
	TOTAL	4										100						
Cefepime	ABSCCESS/WOUNDS	22				5					95		100					
	BLOODS	20			5	20		25	30		90							
	BODY FLUIDS	8				13					100							
	MISCELLANEOUS	8									100							
	RESPIRATORY	19				16			21		100							
	STOOL/URINES	48							2		100							
	TISSUE	4				25					100							
	TOTAL	129			1	8		9	11		98		98					
Cefazolin	ABSCCESS/WOUNDS	102												45				
	BLOODS	66												48				
	BODY FLUIDS	46												41				
	CSF	1												100				
	GENITAL	2												50				
	MISCELLANEOUS	21												62				
	RESPIRATORY	85										1	49					
	STOOL/URINES	182										1	52					
	TISSUE	20												40				
	TOTAL	525												49				
Ciprofloxacin	ABSCCESS/WOUNDS	102				92			93		100							
	BLOODS	66		5		85		86	88		100							
	BODY FLUIDS	47				87			89		100							
	CSF	1				100												
	GENITAL	2				100												
	MISCELLANEOUS	21				90					100							
	RESPIRATORY	86		2	3	86		87	90		100							
	STOOL/URINES	182			1	87		88	90		100							
	TISSUE	20				95					100							
	TOTAL	527		1	1	88		89	91		100							
Cefotaxime	RESPIRATORY	1										100						
	STOOL/URINES	4										100						
	TOTAL	5										100						
Ceftriaxone	ABSCCESS/WOUNDS	21												100				
	BLOODS	14												93				
	BODY FLUIDS	7												100				
	MISCELLANEOUS	8												100				
	RESPIRATORY	14												93				
	STOOL/URINES	48							2					96				
	TISSUE	3												100				
	TOTAL	115							1					97				
Ofurantoine	ABSCCESS/WOUNDS	102																
	BLOODS	66																

(continued on next page)

from 10/15/1995 to 01/28/2000

for Locations Selected

HOSP ID : CLI

Drug	Source	Count	<.06	.06	<.5	.5	<1	1	2	<4	4	<8	8	>8	<10	10	MORE	MICS-->
	BODY FLUIDS	46																
	CSF	1																
	GENITAL	2																
	MISCELLANEOUS	21																
	RESPIRATORY	83																
	STOOL/URINES	182																
	TISSUE	20																
	TOTAL	523																
Gentamicin	ABSCCESS/WOUNDS	102				87			88		89							
	BLOODS	66				83		85	86		88							
	BODY FLUIDS	47				81			83		85			87				
	CSF	1				100												
	GENITAL	2				100												
	MISCELLANEOUS	21				95												
	RESPIRATORY	86			1	86								88				
	STOOL/URINES	182			1	86			89				90	90				
	TISSUE	20				90		95										
	TOTAL	527				86		86	88		89		89	90				
Imipenem	ABSCCESS/WOUNDS	102									100							
	BLOODS	66						3			100							
	BODY FLUIDS	47						2			100							
	CSF	1									100							
	GENITAL	2									100							
	MISCELLANEOUS	21									100							
	RESPIRATORY	86					1	2		3	100							
	STOOL/URINES	182				1	1			2	100							
	TISSUE	20						5			100							
	TOTAL	527					1	2		2	100							
Mazlocillin	BODY FLUIDS	1																
	RESPIRATORY	1																
	TOTAL	2																
Ofloxacin	RESPIRATORY	1						100										
	STOOL/URINES	4						100										
	TOTAL	5						100										
Piperacillin	ABSCCESS/WOUNDS	102											78					
	BLOODS	66											71					
	BODY FLUIDS	47											72					
	CSF	1											100					
	GENITAL	2											100					
	MISCELLANEOUS	21											90					
	RESPIRATORY	86										1	78					
	STOOL/URINES	181											73					
	TISSUE	20											80					
	TOTAL	526											76					
Piperacillin/Ta	ABSCCESS/WOUNDS	21											76					
	BLOODS	20							15				65					
	BODY FLUIDS	8											63					

(continued on next page)

Minimal Inhibitory Concentration Report for *Klebsiella oxytoca*
from 10/15/1995 to 01/28/2000

4

for Locations Selected

HOSP ID : CL1

Drug	Source	Count	<.06	.06	<.5	.5	<1	1	2	<4	4	<8	8	>8	<10	10	MORE NICS-->
	MISCELLANEOUS	8											100				
	RESPIRATORY	18						6	11				72				
	STOOL/URINES	48											85				
	TISSUE	4						25					75				
	TOTAL	127						2	5				78				
Study L	BLOODS	6	17	83								100					
	BODY FLUIDS	1										100					
	RESPIRATORY	3		67								100					
	TOTAL	10	10	70								100					
Study H	BLOODS	6		17	100												
	BODY FLUIDS	1			100												
	RESPIRATORY	3			100												
	TOTAL	10		10	100												
Trimeth-sulfaz	ABSCSS/WOUNDS	102															96
	BLOODS	66						2									86
	BODY FLUIDS	46				2		4									91
	CSF	1															100
	GENITAL	2															100
	MISCELLANEOUS	21				5											90
	RESPIRATORY	85			1		2	4									89
	STOOL/URINES	182						1						1	2		88
	TISSUE	20						5									95
	TOTAL	525				1	1	2						2	2		90
Ceftazidime	ABSCSS/WOUNDS	75										1	96				
	BLOODS	56		2	5				7		9		89				
	BODY FLUIDS	27											96				
	CSF	1											100				
	GENITAL	1											100				
	MISCELLANEOUS	17											100				
	RESPIRATORY	70				3			4				97				
	STOOL/URINES	134							1			1	95				
	TISSUE	16							6				100				
	TOTAL	397				1			2		3	3	95				
Tetracycline	ABSCSS/WOUNDS	61						64	77			87	89				
	BLOODS	46						61	72			80	83				
	BODY FLUIDS	18						50	67			72	78				
	CSF	1						100									
	GENITAL	1						100									
	MISCELLANEOUS	13						85				92					
	RESPIRATORY	40						68	75			90	93				
	STOOL/URINES	103					1	62	74			88					
	TISSUE	13						62	85				92				
	TOTAL	296						64	75			86	88				
Ticarcillin	BODY FLUIDS	1															
	RESPIRATORY	1															
	TOTAL	2															

(continued on next page)

from 10/15/1995 to 01/28/2000

for Locations Selected

HOSP ID : CL1

Drug	Source	Count	<.06	.06	<.5	.5	<1	1	2	<4	4	<8	8	>8	<10	10	MORE MICs-->
Ampicillin/Cla	ABSCCESS/WOUNDS	81															
	BLOODS	52							4		6						
	BODY FLUIDS	39															
	CSF	1															
	GENITAL	2															
	MISCELLANEOUS	13															
	RESPIRATORY	70						1			3						
	STOOL/URINES	134															
	TISSUE	17											6				
	TOTAL	409							1		1		1				
Ceftizoxime	ABSCCESS/WOUNDS	81											99				
	BLOODS	49							2				98				
	BODY FLUIDS	37											100				
	CSF	1											100				
	GENITAL	2											100				
	MISCELLANEOUS	13											100				
	RESPIRATORY	70						1				3	99				
	STOOL/URINES	138										1	100				
	TISSUE	17						6					100				
	TOTAL	408						1				1	99				
Tobramycin	ABSCCESS/WOUNDS	67				90		91	96								
	BLOODS	48				85		88	94					96			
	BODY FLUIDS	21				86		90					95				
	CSF	1				100											
	GENITAL	1				100											
	MISCELLANEOUS	16				100											
	RESPIRATORY	49			2	86			90				94	96			
	STOOL/URINES	124				88			93		94		94				
	TISSUE	14				93		100									
	TOTAL	341				88		89	94		94		95	96			

(continued on next page)

10:20

Minimal Inhibitory Concentration Report for *Klebsiella oxytoca*
 from 10/15/1995 to 01/28/2000
 for Locations Selected
 HDSP ID : CL1

6

Drug	Source	Count	<16	16	>16	20	<32	32	>32	40	64	80	128	>128	160	>160	MORE MICs-->
Pillin	ABSCCESS/WOUNDS	102		2				100									
	BLOODS	66			2			100									
	BODY FLUIDS	46			2			98	100								
	CSF	1						100									
	GENITAL	2						100									
	MISCELLANEOUS	21						100									
	RESPIRATORY	85		2	5			99	100								
	STOOL/URINES	181		1	2			99	100								
	TISSUE	20			5			100									
	TOTAL	524		1	2			99	100								
Amikacin	ABSCCESS/WOUNDS	68															
	BLOODS	51															
	BODY FLUIDS	21															
	CSF	1															
	GENITAL	1															
	MISCELLANEOUS	16															
	RESPIRATORY	49															
	STOOL/URINES	123															
	TISSUE	14															
	TOTAL	344															
Ampicillin-Salb	ABSCCESS/WOUNDS	21		81				100									
	BLOODS	14		71				100									
	BODY FLUIDS	7		86				100									
	MISCELLANEOUS	8		100													
	RESPIRATORY	15		80				100									
	STOOL/URINES	48		88	90			100									
	TISSUE	3		67				100									
	TOTAL	116		84	84			100									
Amoxicillin-Clav	ABSCCESS/WOUNDS	81		84				100									
	BLOODS	52		75	77			100									
	BODY FLUIDS	39		74	77			100									
	CSF	1															
	GENITAL	2															
	MISCELLANEOUS	13						100									
	RESPIRATORY	70		80	81			100									
	STOOL/URINES	134		81				100									
	TISSUE	17						100									
	TOTAL	409		80	81			100									
Aztreonam	ABSCCESS/WOUNDS	54						100									
	BLOODS	36			83			100									
	BODY FLUIDS	16			81			100									
	CSF	1															
	GENITAL	1															
	MISCELLANEOUS	11															
	RESPIRATORY	41			95			100									
	STOOL/URINES	91		91				100									
	TISSUE	12															
	TOTAL	263		89	90			100									

(continued on next page)

Minimal Inhibitory Concentration Report for *Klebsiella oxytoca*

from 10/15/1995 to 01/28/2000

for Locations Selected

HOSP ID : CL1

Drug	Source	Count	<16	16	>16	20	<32	32	>32	40	64	80	128	>128	160	>160	MORE MICs-->
Cefotaxime	RESPIRATORY	1		100													
	STOOL/URINES	4		100													
	TOTAL	5		100													
Cefuroxime	STOOL/URINES	4															
	TOTAL	4															
Cefepime	ABSCSS/WOUNDS	22															
	BLOODS	20		95				100									
	BODY FLUIDS	8															
	MISCELLANEOUS	8															
	RESPIRATORY	19															
	STOOL/URINES	48															
	TISSUE	4															
	TOTAL	129		99				100									
Cefazolin	ABSCSS/WOUNDS	102		83				100									
	BLOODS	66		71	73			100									
	BODY FLUIDS	46		76	78			100									
	CSF	1															
	GENITAL	2		100													
	MISCELLANEOUS	21		86				100									
	RESPIRATORY	85		79	81			100									
	STOOL/URINES	182		79	80			100									
	TISSUE	20		80				100									
	TOTAL	525		79	80			100									
Ciprofloxacin	ABSCSS/WOUNDS	102															
	BLOODS	66															
	BODY FLUIDS	47															
	CSF	1															
	GENITAL	2															
	MISCELLANEOUS	21															
	RESPIRATORY	86															
	STOOL/URINES	182															
	TISSUE	20															
	TOTAL	527															
Cefotaxime	RESPIRATORY	1															
	STOOL/URINES	4															
	TOTAL	5															
Ceftriaxone	ABSCSS/WOUNDS	21															
	BLOODS	14						100									
	BODY FLUIDS	7															
	MISCELLANEOUS	8															
	RESPIRATORY	14		100													
	STOOL/URINES	48		100													
	TISSUE	3															
	TOTAL	115		99				100									
Meropenem	ABSCSS/WOUNDS	102						96		100							
	BLOODS	66						97		98		100					

(continued on next page)

Minimal Inhibitory Concentration Report for *Klebsiella oxytoca*
 from 10/15/1995 to 01/28/2000
 for Locations Selected
 HOSP ID : CL1

Drug	Source	Count	<16	16	>16	20	<32	32	>32	40	64	80	128	>128	160	>160	MORE MICs-->
	BODY FLUIDS	46						96			98		100				
	CSF	1						100									
	GENITAL	2						100									
	MISCELLANEOUS	21						90			95		100				
	RESPIRATORY	83						96			100						
	STOOL/URINES	182					1	94			96		100				
	TISSUE	20						100									
	TOTAL	523						95			98		100				
Gentamicin	ABSCCESS/WOUNDS	102				100											
	BLOODS	66				100											
	BODY FLUIDS	47				100											
	CSF	1															
	GENITAL	2															
	MISCELLANEOUS	21				100											
	RESPIRATORY	86				100											
	STOOL/URINES	182				100											
	TISSUE	20				100											
	TOTAL	527				100											
Imipenem	ABSCCESS/WOUNDS	102															
	BLOODS	66															
	BODY FLUIDS	47															
	CSF	1															
	GENITAL	2															
	MISCELLANEOUS	21															
	RESPIRATORY	86															
	STOOL/URINES	182															
	TISSUE	20															
	TOTAL	527															
Mezlocillin	BODY FLUIDS	1				100											
	RESPIRATORY	1				100											
	TOTAL	2				50		100									
Ofloxacin	RESPIRATORY	1															
	STOOL/URINES	4															
	TOTAL	5															
Piperacillin	ABSCCESS/WOUNDS	102				80		82			84		85				
	BLOODS	66				73							74	76			
	BODY FLUIDS	47									77		81	83			
	CSF	1															
	GENITAL	2															
	MISCELLANEOUS	21															
	RESPIRATORY	86				79					81		84	86			
	STOOL/URINES	181				78					79		81	82			
	TISSUE	20															
	TOTAL	526				78		79			80		82	83			
Piperacillin/Ta	ABSCCESS/WOUNDS	21											100				
	BLOODS	20											85	100			
	BODY FLUIDS	8				75							88	100			

(continued on next page)

from 10/15/1995 to 01/28/2000

for Locations Selected

HOSP ID : CL1

Drug	Source	Count	<16	16	>16	20	<32	32	>32	40	64	80	128	>128	160	>160	MORE MICs-->
	MISCELLANEOUS	8															
	RESPIRATORY	18		83									94	100			
	STOOL/URINES	48		92									100				
	TISSUE	4											100				
	TOTAL	127		83									96	100			
Study L	BLOODS	6															
	BODY FLUIDS	1															
	RESPIRATORY	3															
	TOTAL	10															
Study #	BLOODS	6															
	BODY FLUIDS	1															
	RESPIRATORY	3															
	TOTAL	10															
Trimeth-sulfame	ABSCCESS/WOUNDS	102															
	BLOODS	66										88			89		
	BODY FLUIDS	46													93		
	CSF	1															
	GENITAL	2															
	MISCELLANEOUS	21				95											
	RESPIRATORY	85								91		92			94		
	STOOL/URINES	182							88	90					90	91	
	TISSUE	20															
	TOTAL	525				90		91		91		92			93	93	
Ceftazidime	ABSCCESS/WOUNDS	75		97				100									
	BLOODS	56		93				98	100								
	BODY FLUIDS	27						100									
	CSF	1															
	GENITAL	1															
	MISCELLANEOUS	17															
	RESPIRATORY	70		99	100												
	STOOL/URINES	134		99				100									
	TISSUE	16															
	TOTAL	397		97	98			100	100								
Tetracycline	ABSCCESS/WOUNDS	61		100													
	BLOODS	46		100													
	BODY FLUIDS	18		100													
	CSF	1															
	GENITAL	1															
	MISCELLANEOUS	13		100													
	RESPIRATORY	40		100													
	STOOL/URINES	103		100													
	TISSUE	13		100													
	TOTAL	296		100													
Ticarcillin	BODY FLUIDS	1															
	RESPIRATORY	1											100				
	TOTAL	2											50				

(continued on next page)

MINIMAL INHIBITORY CONCENTRATION REPORT FOR KLEBSIELLA OXYTOSA

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from 10/15/1995 to 01/28/2000

for Locations Selected

HOSP ID ; CL1

Drug	Source	Count	<16	16	>16	20	<32	32	>32	40	64	80	128	>128	160	>160	MORE MICs-->
1 cillin/Cla	ABSCCESS/WOUNDS	81		84									86				
	BLOODS	52		71				73					77	79			
	BODY FLUIDS	39		69				72					74	77			
	CSF	1		100													
	GENITAL	2		100													
	MISCELLANEOUS	13		85													
	RESPIRATORY	70	4	77							81		83	86			
	STOOL/URINES	134	1	78				80			81		85				
	TISSUE	17		82													
	TOTAL	409	2	78				79			80		83	84			
Ceftizoxime	ABSCCESS/WOUNDS	81		100													
	BLOODS	49		100													
	BODY FLUIDS	37															
	CSF	1															
	GENITAL	2															
	MISCELLANEOUS	13															
	RESPIRATORY	70						100									
	STOOL/URINES	138															
	TISSUE	17															
	TOTAL	408		100				100									
Tobramycin	ABSCCESS/WOUNDS	67		100													
	BLOODS	48		100													
	BODY FLUIDS	21		100													
	CSF	1															
	GENITAL	1															
	MISCELLANEOUS	16															
	RESPIRATORY	49		100													
	STOOL/URINES	124		100													
	TISSUE	14															
	TOTAL	341		100													

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Minimal Inhibitory Concentration Report for *Klebsiella oxytoca*
from 10/15/1995 to 01/28/2000
for Locations Selected
HOSP ID : CL1

Drug	Source	Count	256	320
Amikacin	ABSCSS/WOUNDS	102		
	BLOODS	66		
	BODY FLUIDS	46		
	CSF	1		
	GENITAL	2		
	MISCELLANEOUS	21		
	RESPIRATORY	85		
	STOOL/URINES	181		
	TISSUE	20		
	TOTAL	524		
Amikacin	ABSCSS/WOUNDS	68		
	BLOODS	51		
	BODY FLUIDS	21		
	CSF	1		
	GENITAL	1		
	MISCELLANEOUS	16		
	RESPIRATORY	49		
	STOOL/URINES	123		
	TISSUE	14		
	TOTAL	344		
Ampicillin-Sulb	ABSCSS/WOUNDS	21		
	BLOODS	14		
	BODY FLUIDS	7		
	MISCELLANEOUS	8		
	RESPIRATORY	15		
	STOOL/URINES	48		
	TISSUE	3		
	TOTAL	116		
Amoxicillin-Cl	ABSCSS/WOUNDS	81		
	BLOODS	52		
	BODY FLUIDS	39		
	CSF	1		
	GENITAL	2		
	MISCELLANEOUS	13		
	RESPIRATORY	70		
	STOOL/URINES	134		
	TISSUE	17		
	TOTAL	409		
Aztreonam	ABSCSS/WOUNDS	54		
	BLOODS	36		
	BODY FLUIDS	16		
	CSF	1		
	GENITAL	1		
	MISCELLANEOUS	11		
	RESPIRATORY	41		
	STOOL/URINES	91		
	TISSUE	12		
	TOTAL	263		

(continued on next page)

10:20

Minimal Inhibitory Concentration Report for *Klebsiella oxytoca*
from 10/15/1995 to 01/28/2000
for Locations Selected
HOSP ID : CLI

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Drug	Source	Count	256	320
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tetan	RESPIRATORY	1		
	STOOL/URINES	4		
	TOTAL	5		

Cefuroxime	STOOL/URINES	4		
	TOTAL	4		

Cefepime	ABSCCESS/WOUNDS	22		
	BLOODS	20		
	BODY FLUIDS	8		
	MISCELLANEOUS	8		
	RESPIRATORY	19		
	STOOL/URINES	48		
	TISSUE	4		
	TOTAL	129		

Cefazolin	ABSCCESS/WOUNDS	102		
	BLOODS	66		
	BODY FLUIDS	46		
	CSF	1		
	GENITAL	2		
	MISCELLANEOUS	21		
	RESPIRATORY	85		
	STOOL/URINES	182		
	TISSUE	20		
TOTAL	525			

Ciprofloxacin	ABSCCESS/WOUNDS	102		
	BLOODS	66		
	BODY FLUIDS	47		
	CSF	1		
	GENITAL	2		
	MISCELLANEOUS	21		
	RESPIRATORY	86		
	STOOL/URINES	182		
	TISSUE	20		
TOTAL	527			

Cefotaxime	RESPIRATORY	1		
	STOOL/URINES	4		
	TOTAL	5		

Ceftriaxone	ABSCCESS/WOUNDS	21		
	BLOODS	14		
	BODY FLUIDS	7		
	MISCELLANEOUS	8		
	RESPIRATORY	14		
	STOOL/URINES	48		
	TISSUE	3		
TOTAL	115			

ofurantoine	ABSCCESS/WOUNDS	102		
	BLOODS	66		

(continued on next page)

from 10/15/1995 to 01/28/2000

for Locations Selected

HOSP ID : CL1

Drug	Source	Count	256	320
	BODY FLUIDS	46		
	CSF	1		
	GENITAL	2		
	MISCELLANEOUS	21		
	RESPIRATORY	83		
	STOOL/URINES	182		
	TISSUE	20		
	TOTAL	529		
Gentamicin	ABSCCESS/WOUNDS	102		
	BLOODS	66		
	BODY FLUIDS	47		
	CSF	1		
	GENITAL	2		
	MISCELLANEOUS	21		
	RESPIRATORY	86		
	STOOL/URINES	182		
	TISSUE	20		
	TOTAL	527		
Imipenem	ABSCCESS/WOUNDS	102		
	BLOODS	66		
	BODY FLUIDS	47		
	CSF	1		
	GENITAL	2		
	MISCELLANEOUS	21		
	RESPIRATORY	86		
	STOOL/URINES	182		
	TISSUE	20		
	TOTAL	527		
Mezlocillin	BODY FLUIDS	1		
	RESPIRATORY	1		
	TOTAL	2		
Ofloxacin	RESPIRATORY	1		
	STOOL/URINES	4		
	TOTAL	5		
Piperacillin	ABSCCESS/WOUNDS	102	100	
	BLOODS	66	100	
	BODY FLUIDS	47	100	
	CSF	1		
	GENITAL	2		
	MISCELLANEOUS	21	100	
	RESPIRATORY	86	100	
	STOOL/URINES	181	100	
	TISSUE	20	100	
	TOTAL	526	100	
Piperacillin/Ta	ABSCCESS/WOUNDS	21		
	BLOODS	20		
	BODY FLUIDS	8		

(continued on next page)

from 10/15/1995 to 01/28/2000

for Locations Selected

HOSP ID : CL1

Drug	Source	Count	256	320
	MISCELLANEOUS	8		
	RESPIRATORY	18		
	STOOL/URINES	48		
	TISSUE	4		
	TOTAL	127		
Study L	BLOODS	6		
	BODY FLUIDS	1		
	RESPIRATORY	3		
	TOTAL	10		
Study W	BLOODS	6		
	BODY FLUIDS	1		
	RESPIRATORY	3		
	TOTAL	10		
Trimeth-sulfame	ABSCSS/HOUNDS	102	100	
	BLOODS	66	100	
	BODY FLUIDS	46	100	
	CSF	1		
	GENITAL	2		
	MISCELLANEOUS	21	100	
	RESPIRATORY	85	100	
	STOOL/URINES	182	100	
	TISSUE	20	100	
	TOTAL	525	100	
Ceftazidime	ABSCSS/HOUNDS	75		
	BLOODS	56		
	BODY FLUIDS	27		
	CSF	1		
	GENITAL	1		
	MISCELLANEOUS	17		
	RESPIRATORY	70		
	STOOL/URINES	134		
	TISSUE	16		
	TOTRL	397		
Tetracycline	ABSCSS/HOUNDS	61		
	BLOODS	46		
	BODY FLUIDS	18		
	CSF	1		
	GENITAL	1		
	MISCELLANEDUS	13		
	RESPIRATORY	40		
	STOOL/URINES	103		
	TISSUE	13		
	TOTAL	296		
Ticarcillin	BODY FLUIDS	1	100	
	RESPIRATORY	1		
	TOTAL	2	100	

(continued on next page)

from 10/15/1995 to 01/28/2000

for Locations Selected

HOSP ID : CL1

Drug Source Count 256 320

Drug	Source	Count	256	320
7 cillin/Cla	ABSCCESS/WOUNDS	81	100	
	BLOODS	52	100	
	BODY FLUIDS	39	100	
	CSF	1		
	GENITAL	2		
	MISCELLANEOUS	13	100	
	RESPIRATORY	70	100	
	STOOL/URINES	134	100	
	TISSUE	17	100	
TOTAL	409	100		

Ceftizoxime	ABSCCESS/WOUNDS	81		
	BLOODS	49		
	BODY FLUIDS	37		
	CSF	1		
	GENITAL	2		
	MISCELLANEOUS	13		
	RESPIRATORY	70		
	STOOL/URINES	138		
	TISSUE	17		
TOTAL	408			

Tobramycin	ABSCCESS/WOUNDS	67		
	BLOODS	48		
	BODY FLUIDS	21		
	CSF	1		
	GENITAL	1		
	MISCELLANEOUS	16		
	RESPIRATORY	49		
	STOOL/URINES	124		
	TISSUE	14		
TOTAL	341			

Report Completed

LAST	MRN	ONSET	SOURCE	SPEC SITE	PATHOGEN
	60395144	6/02/97	D3	Bacteremia	Klebsiella oxytoca
	23160277	6/11/97	B1	Bacteremia	Klebsiella oxytoca
	60395144	6/12/97		Pneumonia	Klebsiella oxytoca
	24923762	7/31/97	J1	Bacteremia	Klebsiella oxytoca
	22569554	8/08/97	X	Bacteremia	Klebsiella oxytoca
	13822506	10/26/97	B1	Bacteremia	Klebsiella oxytoca
	26126339	1/24/98	F3	Bacteremia	Klebsiella oxytoca
	26266696	4/19/98		UTI	Klebsiella oxytoca
	27266983	7/26/98	X	Bacteremia	Klebsiella oxytoca
	20355611	9/13/98	J1	Bacteremia	Klebsiella oxytoca
Zimmerman	27448380	10/04/98	F3	Bacteremia	Klebsiella oxytoca
	04599209	2/10/99	D1	Bacteremia	Klebsiella oxytoca
	17963830	3/31/99	B	Bacteremia	Klebsiella oxytoca
	24024962	4/05/99	X	Bacteremia	Klebsiella oxytoca
	23848198	6/09/99	X	Bacteremia	Klebsiella oxytoca
	26925550	7/23/99	X	Bacteremia	Klebsiella oxytoca
	16229342	10/13/99	X	Bacteremia	Klebsiella oxytoca
	60363609	11/12/99		Pneumonia	Klebsiella oxytoca

1/28/00

Standard Report

Unit	LAST	MRN	ONSET	SOURCE	SPEC SITE	PATHOGEN
G61		20438207	3/16/93		Tracheobronchitis	Klebsiella oxytoca
G90		21890090	5/29/93	D1	Bacteremia	Klebsiella oxytoca
H80		15341661	6/16/93	B1	Bacteremia	Klebsiella oxytoca
G54		05922259	7/23/93	D3	Bacteremia	Klebsiella oxytoca
G53		22026879	1/02/94		Pneumonia	Klebsiella oxytoca
G61		22206028	1/15/94		Tracheobronchitis	Klebsiella oxytoca
G50		14290028	2/04/94		Tracheobronchitis	Klebsiella oxytoca
G61		22424505	3/05/94		Pneumonia	Klebsiella oxytoca
O51		23240971	5/09/94		Pneumonia	Klebsiella oxytoca
G20		06905854	7/29/94	D3	Bacteremia	Klebsiella oxytoca
G52		22837907	9/14/94		Pneumonia	Klebsiella oxytoca
G52		11656773	10/24/94		Pneumonia	Klebsiella oxytoca
G51		22979400	3/13/95		Pneumonia	Klebsiella oxytoca
G62		17141970	6/08/95	X	Bacteremia	Klebsiella oxytoca
G100		23276380	7/04/95	F1	Bacteremia	Klebsiella oxytoca
M43		23368579	7/22/95		Pneumonia	Klebsiella oxytoca
G61		20544511	8/10/95	B1	Bacteremia	Klebsiella oxytoca
G91		20526467	11/08/95	C3	Bacteremia	Klebsiella oxytoca
G53		22450646	11/13/95	B1	Bacteremia	Klebsiella oxytoca
G80		23830949	12/29/95	B1	Bacteremia	Klebsiella oxytoca
G51		11822797	2/08/96		Tracheobronchitis	Klebsiella oxytoca
H60		11858600	2/23/96	C3	Bacteremia	Klebsiella oxytoca
G51		23938367	2/29/96		Pneumonia	Klebsiella oxytoca
G51		23938367	2/29/96	D3	Bacteremia	Klebsiella oxytoca
H71		24335372	9/27/96	X	Bacteremia	Klebsiella oxytoca
M50		24119378	12/16/96	E1	Bacteremia	Klebsiella oxytoca
O54		24544796	12/24/96	X	Bacteremia	Klebsiella oxytoca
If70		22489810	2/17/97	C	Bacteremia	Klebsiella oxytoca
G51		25391039	3/01/97		Tracheobronchitis	Klebsiella oxytoca
M71		23990423	4/13/97	B3	Bacteremia	Klebsiella oxytoca

1/28/00

Standard Report

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LAST	MRN	SURG_DATE	GEN_DESC	STAFF_CODE	ONSET	SPEC_DESC	PATH_CODE
	22646087	6/18/94	Colorectal Surg	409	7/06/94	Organ/Space	248
	22770012	8/25/94	Cardiovas. Surg	274	9/06/94	Incisional, deep	248
	24582760	1/07/97	Cardiovas. Surg	070	1/26/97	SVG Site (infection)	248
	60117721	10/28/97	Orthopaedic	4002	11/20/97	Incisional, deep	248
	26126339	1/20/98	Cardiovas. Surg	665	1/25/98	Incisional, deep	248
	16208906	4/22/98	Neurosurgery	843	5/13/98	Organ/Space	248
	27214355	5/19/98	Cardiovas. Surg	514	5/31/98	Incisional, superfic	248
	27194486	8/13/98	Cardiovas. Surg	856	8/24/98	Incisional, superfic	248
Zimmerman	27448380	9/22/98	Neurosurgery	852	10/04/98	Organ/Space	248
	12801858	5/06/99	Neurosurgery	843	5/20/99	Incisional, deep	248